

UnitedHealthcare Choice Plus

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, 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 Group's office during regular business hours.

Can This Certificate Change?

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

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval with a 60-day prior written notice. 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 shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our

reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed except when 1) the bill is considered a surprise bill under Maine law; or 2) we approve an exception for you to see the out-of-Network provider because our Network is not adequate. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Protection from Surprise Bills

With respect to a surprise bill or a bill for covered Emergency Health Care Services rendered by an out-of-Network provider:

- A. We will require you to pay only the applicable Co-insurance, Co-payment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a Network provider. We will calculate any Co-insurance amount based on the median Network rate for that service.
- B. Except as provided for ambulance services, unless we and the out-of-Network provider agree otherwise, we will reimburse the out-of-Network provider or enrollee, as applicable, for health care services rendered at the greater of:
 1. Our median Network rate paid for that service by a similar provider in the geographic area where the service was provided; and
 2. The median Network rate paid by all insurers for that service by a similar provider in the geographic area where the service was provided as determined by the all-payer claims database maintained by the Maine Health Data Organization or, if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database specified by the superintendent.
- C. If we have an inadequate Network, as determined by the superintendent, we will ensure that you obtain the covered service at no greater cost to you than if the service were obtained from a Network provider or will make other arrangements acceptable to the superintendent.
- D. We will reimburse an out-of-Network provider for ambulance services that are covered Emergency Health Care Services at the out-of-Network provider's rate required in accordance with Maine law.
- E. If an out-of-Network provider disagrees with our payment amount for a surprise bill for Emergency Health Care Services or for covered Emergency Health Care Services, we and the out-of-Network provider have 30 calendar days to negotiate an agreement on the payment amount in good faith. If we and the out-of-Network provider do not reach agreement on the payment amount within 30 calendar days, the out-of-Network provider may submit a dispute regarding the payment and receive another payment from us determined in accordance with the dispute resolution process in accordance with Maine law.
- F. Your responsibility for payment for covered out-of-Network Emergency Health Care Services must be limited so that if you have paid your share of the charge as specified in the plan for Network services, we will hold the enrollee harmless from any additional amount owed to an out-of-Network provider for covered Emergency Health Care Services and make payment to the out-of-Network provider in accordance with this section or, if there is a dispute, in accordance with Maine law.

Payment after resolution of disputes: following an independent dispute resolution determination in accordance with Maine law, the determination by the independent dispute resolution entity of a reasonable payment for a specific health care service or treatment rendered by an out-of-Network provider is binding on us, out-of-Network provider and you for 90 days. During that 90-day period, we will reimburse an out-of-Network provider at that same rate for that specific health care service or treatment, and an out-of-Network provider may not dispute any bill for that service in accordance with Maine law.

As used in this section, "surprise bill" means a bill for health care services, including, but not limited to, Emergency Health Care Services, received by you for Covered Health Care Services rendered by an out-of-Network provider at a Network provider, when such services were rendered by that out-of-Network provider at a Network provider, during a service or procedure performed by a Network provider, or during a service or procedure previously approved or authorized us, and you did not knowingly elect to obtain such services from that out-of-Network provider. A surprise bill does not include a bill for health care services received by you when a Network provider was available to render the services and you knowingly elected to obtain the services from another provider who was an out-of-Network provider.

As used in this section, "Knowingly elected to obtain such services from that out-of-Network provider" means that you chose the services of a specific provider, with full knowledge that the provider is an out-of-Network provider with respect to your health plan, under circumstances that indicate that you had and was informed of the opportunity to receive services from a Network provider but instead selected the out-of-Network provider. The disclosure by a provider of Network status does not render your decision to proceed with treatment from that provider a choice made knowingly pursuant to this subsection.

Offer Health Education Services to You

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

Explanation and Notice to Parent

If the Covered Person is an Enrolled Dependent child, and the parent of the Covered Person makes the request, we will provide the parent with:

- **Payment or denial of claim.** An explanation of the payment or denial of any claim filed on behalf of the Covered Person, except to the extent that the Covered Person has the right to withhold consent and does not affirmatively consent to notifying the parent.
- **Change in terms and conditions.** An explanation of any proposed change in the terms and conditions of the Policy.
- **Notice of lapse.** Reasonable notice that the Policy may lapse, but only if the parent has provided us with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary to us to process a claim will be permitted to authorize the filing of any claim under the Policy.

Comparable Health Care Services Incentive Program

The Covered Person is encouraged to shop for low-cost, high-quality providers for comparable health care services. "Comparable health care services" means nonemergency, outpatient health care services in the following categories: (1) physical and occupational therapy services, (2) radiology and imaging services, (3) laboratory services, and (4) infusion therapy services. If you need comparable health care services, you are encouraged to contact one of our representatives by calling the telephone number on Your ID card or emailing the email address on Your ID card. We can help you find a provider that is right for you. In addition, for shopping and utilizing this program, you will receive a \$25 gift card for each time you shop a service category with a maximum of \$200 for utilizing this program.

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services	10
Section 2: Exclusions and Limitations	34
Section 3: When Coverage Begins	46
Section 4: When Coverage Ends	50
Section 5: How to File a Claim	54
Section 6: Questions, Complaints and Appeals	56
Section 7: Coordination of Benefits	63
Section 8: General Legal Provisions	69
Section 9: Defined Terms	78
Section 10: Travel and Lodging Program	91

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

Benefits are provided for services delivered via Telehealth. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*. A Physician or other provider providing health care services through Telehealth must be acting within the scope of practice of his or her license and complying with applicable standards of practice and board rules regarding telehealth.

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

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

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

1. Ambulance Services

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

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

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.

- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

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

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

2. Autism Spectrum Disorder Treatment

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist for the treatment of Autism Spectrum Disorders.

3. Cellular and Gene Therapy

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

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

4. Children's Early Intervention Services

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*.

5. Clinical Trials

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

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

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

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial and when you meet the following conditions:

- You have a life-threatening illness for which no standard treatment is effective.

- You are eligible to participate according to the clinical trial protocol with respect to treatment of such illness.
- Your participation in the trial offers meaningful potential to you for significant clinical benefit.
- Your referring Physician has concluded that your participation in such a trial would be appropriate based on the satisfaction of the above conditions.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)* 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* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

6. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

7. Dental Anesthesia Services

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 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.
- Covered Persons who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

8. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of Accidental damage.
- You receive dental services from a Doctor of Dental Surgery, Doctor of Medical Dentistry or licensed independent practice dental hygienist.

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

Dental services to repair damage caused by Accidental Injury must follow this time-frame:

- Treatment must be completed within 12 months of the Accident, or if not a Covered Person at the time of the Accident, within the first 12 months of coverage under the Policy.

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

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

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.

9. Diabetes Services

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

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

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

Diabetic Self-Management Items

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

10. Durable Medical Equipment (DME), Orthotics and Supplies

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

DME and Supplies

Examples of DME and supplies include:

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

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

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

Orthotics

Orthotic devices that support, correct or alleviate neuromuscular or musculoskeletal dysfunction, disease, Injury or deformity, limited to custom fabricated, medically appropriate braces or supports.

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

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

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

11. Emergency Health Care Services - Outpatient

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

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

12. Enteral Nutrition

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

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

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

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

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

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

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

13. Family Planning

Family planning services 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.

14. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for embryo transfer.

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

15. Gender Dysphoria

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

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

16. Habilitative Services

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

Habilitative services are limited to:

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

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

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

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.

- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

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

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

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

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

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

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

Habilitative services performed as stated under *Autism Spectrum Disorder Treatment* or under *Mental Health Care and Substance-Related and Addictive Disorders Services* are not subject to the annual visit limits as stated in the *Schedule of Benefits* under either *Rehabilitation Services - Outpatient Therapy* or under *Therapeutic, Adjustive and Manipulative Services*.

17. Hearing Aids

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

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician or state licensed audiologist. Benefits are provided for the hearing aid for each hearing-impaired ear and associated fitting charges and testing.

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

The hearing aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids.

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

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

18. Home Health Care

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

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

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

Home health care visits include the following:

- Visits by a registered Nurse or licensed practical Nurse to carry out treatments prescribed, or supporting 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 lab tests and x-ray examinations 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 if you 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 under this section.

19. 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 who have a prognosis of 12 months or less. It includes the following:

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

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

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 (either at an acute care Hospital or Skilled Nursing Facility). Hospice care services include, but are not limited to the following:

- Physician services.

- Nursing care.
- Respite care.
- Medical and social work services.
- Counseling services.
- Nutritional counseling.
- Pain and symptom management.
- Medical supplies and Durable Medical Equipment (DME).
- Occupational, physical or speech therapies.
- Volunteer services.
- Home health care services.
- Bereavement services.

Coverage for hospice respite care includes Benefits for up to a 48-hour period. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other non-professional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care.

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

20. 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). This Benefit includes general nursing care, special duty nursing and special diets.
- Use of intensive care or coronary care unit; diagnostic services; medical, surgical and central supplies; treatment services; Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy and radiotherapy services; Phase I Cardiac Rehabilitation.
- Medication used while you are an inpatient such as drugs, biologicals and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the following:
 - The diagnosis of cancer, HIV or AIDS.
 - As approved for Medically Necessary indications.
 - As required by law.

Benefits are not provided for any investigational new drugs unless approved by us for medically accepted indications or as required by law.

- Blood or blood derivatives.
- Newborn care, including routine well-baby care.
- Blood transfusions including the cost of blood, blood plasma and blood plasma expanders as well as the administrative costs of autologous blood pre-donations.
- 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 you. Breast reconstruction Benefits are described under *Reconstructive Procedures*.

- 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*.)

21. Infant Formula

Amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula. Benefits 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 Medically Necessary 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 failed or are contraindicated.

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

22. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab, including human leukocyte antigen testing performed to establish bone marrow transplantation suitability, a prostate-specific antigen test to screen for prostate cancer and radiology/X-ray.
- Mammography. 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 include:

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

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

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

23. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

24. Medical Foods

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.

25. Mental Health Care and Substance-Related and Addictive Disorders Services

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

Benefits include Mental Health Care Services for the treatment of Biologically-based Mental Illness, 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). We may not deny treatment for Mental Health Care Services that use "evidence-based practices" and are determined to be Medically Necessary health care for a Dependent 21 years of age or younger. "Evidence-based practices" means clinically sound and scientifically based policies, practices and programs that reflect expert consensus on the prevention, treatment and recovery science, including, but not limited to, policies, practices and programs published and disseminated by the *Substance Abuse and Mental Health Services Administration* and the *Title IV-E Prevention Services Clearinghouse* within the *United States Department of Health and Human Services*, the *What Works Clearinghouse* within the *United States Department of Education, Institute of Education Sciences* and the *California Evidence-Based Clearinghouse for Child Welfare* within the *California Department of Social Services, Office of Child Abuse Prevention*.

Benefits for Substance-Related and Addictive Disorders Services include 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 include the following levels of care:

- Inpatient treatment including 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.

- 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 patient with the illness of alcoholism and drug dependency.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment including screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups.
- Outpatient Benefits are also available for home health care services which means those services rendered by a licensed provider of Mental Health Care Services to provide Medically Necessary Benefits 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 services.

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

Services include the following:

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

ABA means the design, implementation and evaluation of environmental modification 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*.

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

- Counseling services related to Autism Spectrum Disorder provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker.

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

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

26. Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when you have 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.

27. 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.

28. Parenteral and Enteral Therapy

Supplies and equipment needed to appropriately administer parenteral and enteral therapy. Benefits are not available for nutritional supplements for the sole purpose of enhancing dietary intake unless they are given in conjunction with enteral therapy.

29. Pharmaceutical Products - Outpatient

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

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

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

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

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

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

30. Physician Fees for Surgical and Medical Services

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

31. Physician's Office Services - Sickness and Injury

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

Covered Health Care Services include services at a retail health clinic, which are limited to basic health care services on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by a Physician's assistant or Nurse practitioner and are limited to routine care and treatment to common illnesses for adults and children.

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

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

Covered Health Care Services include Genetic Counseling.

Benefits under this section include, but are not limited to the following:

- Allergy testing and injections.
- Removal of sutures, application or removal of a cast or removal of impacted or un-erupted teeth.
- Digital rectal examinations to screen for prostate cancer.

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

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

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

32. Pregnancy - Maternity Services

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

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

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

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

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

Benefits will be provided for postpartum care services for 12 months following childbirth. Coverage will meet the standards of the *American College of Obstetricians and Gynecologists*, as outlined in the "Optimizing Postpartum Care" opinion published May 2018. Coverage will include:

- A postpartum care plan.
- Contact with Covered Person within 3 weeks of end of pregnancy.
- A comprehensive postpartum visit.
- Treatment of complications of pregnancy and childbirth.
- Assessment of risk factors for cardiovascular disease.
- Care related to pregnancy loss.

33. Preimplantation Genetic Testing (PGT) and Related Services

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

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

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

34. 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*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

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

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

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

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include screening for cervical cancer.

35. Prosthetic Devices

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

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

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

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

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

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

36. Reconstructive Procedures

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

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.
- Necessary to correct a birth defect for a Covered Dependent child who has a functional physical deficit due to the birth defect.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly and include Medically Necessary breast reduction surgery and symptomatic varicose vein surgery. The primary result of the procedure is not a changed or improved physical appearance.

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

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

37. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- 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.
- Inhalation therapy.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

38. 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, except for those services described under *Preventive Care Services*. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.
- Colorectal cancer screenings for asymptomatic individuals who are:
 - At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or
 - At high risk for colorectal cancer.

Colorectal cancer screening means all colorectal cancer examinations and laboratory tests recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

If a colonoscopy is recommended as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy Benefits will be paid for the screening colonoscopy as the primary procedure.

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

Benefits include:

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

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

39. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

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

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

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

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

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

40. Smoking Cessation

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. Benefits under this section include nicotine replacement therapy (NRT), including nicotine patches, gum or nasal spray.

41. Surgery - Outpatient

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

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

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Blood administration.
- Blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and the administrative costs of autologous blood pre-donations.

42. Therapeutic, Adjustive and Manipulative Services

Therapeutic, Adjustive and Manipulative Services when performed by a Network 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.

Benefits include self-referral services under the following conditions:

- You may utilize the services of a Network Therapeutic, Adjustive and Manipulative Services provider for 3 weeks or a maximum of 12 visits, whichever occurs first, of acute care treatment without the prior approval of a Network Primary Care Physician. For purposes of this subsection, "acute care treatment" means treatment for accidental bodily injury or sudden, severe pain that affects the ability of the enrollee to engage in the normal activities, duties or responsibilities of daily living.
- Within 3 working days of the first consultation, the Network Therapeutic, Adjustive and Manipulative Services provider shall send to the Primary Care Physician a report containing the complaint, related history, examination, initial diagnosis and treatment plan. If the Therapeutic, Adjustive and Manipulative Services provider fails to send a report to the Primary Care Physician within 3 working days, we are not obligated to provide benefits for Therapeutic, Adjustive and Manipulative Services care and you is not liable to the Therapeutic, Adjustive and Manipulative Services provider for any unpaid fees.
- If you and the Network Therapeutic, Adjustive and Manipulative Services provider determine that your condition has not improved after 3 weeks of treatment or a maximum of 12 visits the Network Therapeutic, Adjustive and Manipulative Services provider shall discontinue treatment and refer you to your Primary Care Physician.

- If the Therapeutic, Adjustive and Manipulative Services provider recommends treatment beyond 3 weeks or a maximum of 12 visits, the Network Therapeutic, Adjustive and Manipulative Services provider shall send to your Primary Care Physician a report containing information your progress and outlining a treatment plan for extended Therapeutic, Adjustive and Manipulative Services care of up to 5 more weeks or a maximum of 12 more visits, whichever occurs first.
- Without the approval of your Primary Care Physician, you may not receive benefits for more than 36 visits to a Network Therapeutic, Adjustive and Manipulative Services provider in a 12-month period. After a maximum of 36 visits, your continuing Therapeutic, Adjustive and Manipulative Services treatment must be authorized by the Primary Care Physician.

43. 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 (which also may be rendered at home).
- Radiation oncology.

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

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

Benefits include:

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

44. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies, allogeneic bone marrow, autologous bone marrow. Bone marrow transplants that are not a Covered Health Care Service are those that are specifically excluded in *Section 2: Exclusions and Limitations*, or those that meet the definition of Experimental or Investigational or Unproven Service in *Section 9: Defined Terms*.
- Heart.
- Heart/lung.
- Lung.
- Islet tissue.
- Kidney.
- Kidney/pancreas.
- Liver.

- Liver/small intestine.
- Adrenal gland, cartilage, muscle, skin and tendon.
- Heart valve.
- Pancreas.
- Small intestine.
- Cornea.
- Blood vessel.
- Parathyroid.

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

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

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

45. Urgent Care Center Services

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

46. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

47. Virtual Care Services

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

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

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

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

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

48. Vision Correction After Surgery or Accident

Prescription, fitting or purchase of glasses or contact lenses for vision correction after surgery or Accident. Coverage is provided as necessary to treat accommodative strabismus, cataracts, or aphakia.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

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

This exclusion does not apply to Accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services* or under *Dental Anesthesia Services* in *Section 1: Covered Health Care Services*.

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.

D. Drugs

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

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

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

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.
13. Off-label use of Pharmaceutical Products 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 Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

F. Foot Care

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

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

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

G. Gender Dysphoria

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

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

H. Medical Supplies and Equipment

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

This exclusion does not apply to:

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

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

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

J. Nutrition

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

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures in Section 1: Covered Health Care Services*.
 3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
 4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
 5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
 6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

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

13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services* and for those surgeries determined to be Medically Necessary.
14. Helicobacter pylori (*H. pylori*) serologic testing.
15. Intracellular micronutrient testing.
16. Cellular and Gene Therapy services not received from a Designated Provider.

N. Providers

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

This exclusion does not apply to mammography.

O. Reproduction

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

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
 - All fees including:
 - ◆ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.

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

P. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. 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. Services resulting from Accidental bodily injuries arising out of a motor vehicle Accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*. This exclusion does not apply to the *Travel and Lodging Program* which is described under *Section 10: Travel and Lodging Program*.

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

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

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

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. For more information about extension of benefits for disabled persons, see *Extended Coverage for Total Disability* under *Section 4: When Coverage Ends*.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. This exclusion does not apply to blood and blood storage related to blood transfusions.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
12. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

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

- We will notify you of the termination of the provider's contract at least sixty days in advance of the termination. When circumstances related to the termination render such notice impossible, we will 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 to be covered, with respect to the course of treatment with the provider, for a transitional period of at least sixty days from the date notice to you of the provider's termination. However, 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 previous item 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 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.

What If You Are Eligible for Medicare?

Your Benefits 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 may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *How Are Benefits Paid When You Are Medicare Eligible?* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.

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

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

Coverage 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 ended for cause, or because premiums were not paid on a timely basis.

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

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

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

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.

- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. 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 Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). 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 if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

Your coverage ends on the 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 definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

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

Fraud or Intentional Misrepresentation of a Material Fact

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

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

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 this age if both of the following are true:

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

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

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

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year after the two-year period following the Enrolled Dependent child's attainment of the limiting age.

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 when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will 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 ends.

Continuation of Coverage

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

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

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

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

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

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

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- The Eligible Person was temporarily laid off
- The Eligible Person was permanently laid off and is eligible for premium assistance pursuant to federal law providing premium assistance for laid-off employees who continue coverage under their former employer's group health plan as determined by the Superintendent
- The member or Eligible Person lost employment because of an Injury or disease that the Eligible Person claims to be compensable under former Title 39 or Title 39-A.

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 get an election form from the Group or the employer and, once election is made, forward all monthly Premiums to the Group for payment to us.

Terminating Events for Continuation Coverage under State Law

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

- One year from the date of your last day of work.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the 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.

Notification of Availability of Individual Coverage

We shall provide forms to the Group and you for the purpose of informing you of your right to purchase any individual health plan available in the state of Maine, including eligibility for any special enrollment period to purchase an individual health plan pursuant to the federal Affordable Care Act, and of the availability of public health coverage options available in the state of Maine, including but not limited to MaineCare coverage. The form will include the following statements:

- All residents of the state of Maine not eligible for Medicare have a right to purchase any individual health plan available in the state of Maine.
- In order to avoid a gap in coverage, you should apply for individual coverage prior to termination of your coverage.
- Information concerning individual coverage is available from the Maine Bureau of Insurance. The Bureau's toll-free telephone number will be provided.
- Termination of coverage may be a qualifying event for a special enrollment period to purchase an individual health plan. The length of time for the special enrollment period and the dates for the next Open Enrollment Period will be provided.
- Financial assistance may be available to you to purchase a qualified health plan through the Maine Health Insurance Marketplace. The marketplace's publicly accessible website and the toll-free telephone number will be provided.
- You may qualify for free health coverage through MaineCare. The MaineCare program's publicly accessible website and toll-free telephone number will be provided.
- You may contact the Health Insurance Consumer Assistance Program for help obtaining health insurance coverage, including additional information and assistance enrolling in coverage. The program's publicly accessible website, toll-free telephone number and e-mail address will be provided.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. You are not responsible for "balance billing" by Network providers. This means that for Network Benefits you are not responsible for any difference between the Allowed Amount and the amount the provider bills. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

Claims for office visits that include *Preventive Care Services* as described under *Section 1: Covered Health Care Services* will be paid in accordance with applicable law. You are not responsible for paying for *Preventive Care Services* received from a Network provider.

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

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

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

Written notice of Sickness or Injury must be provided to us within 30 days after the date when such Sickness or Injury occurred. Within 15 days of receipt of such notification we will provide forms for filing proof of loss. 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

We will provide you with forms required to submit proof of loss. If those forms are not provided to you within 15 days after we receive notice of a claim, you will be deemed to have complied with the requirements of this section as to proof of loss upon submitting your request for payment within the time frame reflected in this section.

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

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

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

Optum Rx
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. 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.

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

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.

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

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

Grievance Procedure

A "grievance" is a written complaint submitted by or on behalf of you regarding any of the following:

- 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.
- Matters pertaining to the contractual relationship between you and us.

If you need assistance in submitting a grievance, you may contact the Superintendent's Office at any time. The address is:

State of Maine Bureau of Insurance
Superintendent's Office
34 State House Station
Augusta, Maine 04333-0034
Telephone: 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 us. We will issue a written decision to you (or your representative) within 20 business days after receiving the grievance and all information necessary for our review of the grievance. Additional time is permitted when we can establish that 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 (or your representative). 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 we make an adverse determination, our decision will be in writing and will contain the following:

- 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 your 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* including the toll-free telephone number and address of the *Bureau of Insurance*.
- A notice describing any external review rights.
- 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 a Covered Health Care Service, 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, and you and your providers will be notified of the determination within two working days of obtaining all necessary information.
- **Prior Authorization Requests for Nonemergency Services.** Except for a request in exigent circumstances, a request by a provider for prior authorization of a nonemergency service must be answered within 72 hours or two business days, whichever is less, in accordance with the following:
 - Both the provider and the enrollee on whose behalf the authorization was requested must be notified of our determination.
 - If we respond to a request with a request for additional information, we will make a decision within 72 hours or two business days, whichever is less, after receiving the requested information.
 - If we respond that outside consultation is necessary before making a decision, we will make a decision within 72 hours or two business days, whichever is less, from the time of our initial response.
 - The prior authorization standards we use will be clear and readily available.
 - A provider must make best efforts to provide all information necessary to evaluate a request, and we will make best efforts to limit requests for additional information.
 - If we do not grant or deny a request for prior authorization within these timeframes, the request is granted.

The Policy will not impose a penalty of more than \$500 for failure to obtain prior authorization.

- **Expedited Review in Exigent Circumstances.** When exigent circumstances exist, we must answer a prior authorization request no more than 24 hours after receiving the request.
 - Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
 - We must notify the enrollee, the enrollee's designee if applicable, and the provider of its coverage decision.
- **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, and you and your provider will be notified of the determination within one working day. In the case of a determination to approve additional

services, the written notification provided within one working day will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation services. In the case of an adverse determination, we will notify you and the provider rendering the service within one working day and the service will continue without liability to you until you have been told of the determination.

- **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. A determination will be made within 30 working days from receipt of all necessary information. In the case of a certification, we will notify you and your provider. In the case of an adverse determination, we will notify you and your provider within five working days of making the determination.
- **Retrospective utilization review for Emergency Health Care Services** may be conducted by us before we deny Benefits or reduce payments for an Emergency Health Care Service based on a determination of the absence of an Emergency medical condition or a determination that a lower level of care was needed. A board-certified Emergency Physician who is licensed in Maine shall conduct such review, including a review of the Covered Person's medical record related to the Emergency medical condition subject to dispute. If we request records related to a potential denial of Benefits or payment reduction when Emergency Health Care Services were furnished to a Covered Person, a provider has an affirmative duty to respond to us in a timely manner. This paragraph does not apply when we make a reduction in payments for Emergency Health Care Services based on a contractually agreed upon adjustment.

If you wish to determine the status or outcome of a clinical review decision you may call us at the telephone number 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 of that provider 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.

Appeals will be conducted by a clinical peer of the treating provider. The clinical peer may not have been involved in making the initial adverse health care treatment decision unless information not previously considered during the initial review is provided on appeal. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision. An adverse health care treatment decision does not include a rescission determination or initial coverage eligibility determination. A "clinical peer" means a Physician or other licensed health care practitioner who holds a non-restricted license in a state in the U.S., is board

certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf us.

An adverse decision will be in writing and will contain the following:

- 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.
- Any appeal rights and the procedure and time limitation for exercising those rights. Notice of external review rights will be provided as well as a description of the process for submitting a written request for second level review.

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 disinterested clinical peers of the treating provider. 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 of the treating provider 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 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.

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

- A statement that 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.
- A statement that 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.
- A statement that 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 you with all relevant information that is not confidential or privileged. You have the right to:

- Obtain your medical file and information relevant to your appeal free of charge upon request.
- 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.
- 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 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.

- The grievance procedures outlined in this section 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.

Prescheduled treatments, therapies, surgeries, or other procedures are not considered urgent situations.

If you are in a situation requiring Emergency or urgent care, we will also provide an expedited review. An Emergency is described in *Section 9 - Defined Terms*. An urgent care 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 you if you have received Emergency Health Care Services but have 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 clinical peer of the treating provider 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, fax or the most expeditious method available within 24 hours of receiving the request. A written confirmation of the decision will follow within two business days of the decision.

If the expedited review is a concurrent review determination of Emergency Health Care Services as described in the *Emergency Health Care Services - Outpatient* section or of an initially noticed 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 in this section. Your failure to obtain authorization prior to receiving an otherwise Covered Health Care Service may not preclude you from exercising your rights under this section.

Request for External Review

You or your authorized representative may make a written request for external review of an adverse health care treatment decision to the *Maine Bureau of Insurance*. You have the right to waive the Second Level Review in order to submit an expedited request for external review as described below. 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. To initiate an external review call the *Maine Bureau of Insurance* at (800) 300-5000 or write to them at 34 State House Station, Augusta, ME 04333.

Expedited Request for External Review

You are not required to exhaust all levels of our internal grievance procedure before filing a request for external review if any of the following apply:

- We have failed to make a decision on an internal grievance within the time period required or have otherwise failed to adhere to the requirements applicable to the grievance pursuant to state or federal law or you have 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 process.
- Your life or health is in serious jeopardy.
- You have died.
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when you have received Emergency Health Care Services but have not been discharged from the facility that provided the Emergency Health Care Services.

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 Care 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.
 - 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 prior paragraph would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

We will 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 Does Coordination of Benefits Apply?

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

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

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

Definitions

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

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; Accident only coverage; specified disease or specified Accident coverage; limited benefit health coverage, as defined by state law; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, Co-insurance and Co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

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

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

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

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

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a newborn dependent child, the Plan providing maternity coverage for the mother is the Primary Plan with respect to routine newborn care services provided to the newborn before the mother's hospital discharge date.
 - b) For a dependent child (other than a newborn dependent child, as discussed in a) above) 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.
 - c) 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.
 - d) 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.
 - e) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
 5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. If a Covered Person is covered under more than one Plan, payments made by the Primary Plan, payments made by the Covered Person and payments made from a health savings account or similar fund for benefits covered under the Secondary Plan must be credited toward the Annual Deductible of the Secondary plan. This does not apply if the Secondary Plan is designed to supplement the Primary Plan.
- D. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary 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 the Coverage Plan's Benefit in these situations, we use Medicare's approved amount or Medicare's limiting charge as the Allowable Expense.

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 will be denied.

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

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

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

Notice

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

If the Premium rate in our agreement with the 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 Group or Subscriber

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

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy and that no such action shall 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.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in the *Schedule of Benefits*.

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

Are Incentives Available to You?

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

We have the authority to do all of the following:

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

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

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

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

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

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.
- Amendment and Rider language must have been filed with and approved by the *Maine Bureau of Insurance* prior to issuance.

However, when renewing the Policy in accordance with this section, we may modify the coverage, terms and conditions of the Policy consistent with other applicable provisions of state and federal laws as long as the modifications are applied uniformly to all policyholders of the same product.

We will provide written notice to the Subscriber at least 60 days in advance of any material modification, including changes in Preventive Care Services.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense. We also have the right to make an autopsy in case of death where it is not prohibited by law.

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Medicare Eligible?

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

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

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

Subrogation Example:

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

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

Reimbursement Example:

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past

medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

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" means that any factors that diminish the potential value of the claim will likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors 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 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 you.

When Do We Receive Refunds of Overpayments?

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

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

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

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

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

Is There a Limitation of Action?

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

When is Continuity of Coverage Under Maine Law Provided?

Continuity of coverage is provided under Maine law within 90 days before the date you were either:

- Enrolled under this Policy; or
- Would have been eligible to enroll except for a waiting period for coverage established by the Group, provided you enrolled when initially eligible to do so.

Continuity of coverage is provided under Maine law within 180 days before the date you enrolled under the Policy (or would have been eligible except for a waiting period for coverage established by the Group and you did enroll when initially eligible), if all of the following conditions are met:

- Prior coverage was terminated due to unemployment.
- You received unemployment compensation for the period of unemployment.
- You were employed when coverage commenced under this Policy.

What Is the Entire Policy?

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

Section 9: Defined Terms

Accident/Accidental - accidental bodily Injury sustained by you while this Policy is in force and that is the direct cause of the condition for which Benefits are provided.

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

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

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

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

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

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

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

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

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

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

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

Autism Spectrum Disorder - any of the pervasive developmental disorders as defined by the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

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

Biologically-based Mental Illness - any of the following biologically-based Mental Illness as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* as a biologically-based mental illness (except for those that are designated as "V" codes):

- 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.
- Substance use disorders.

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

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

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

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

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

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

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

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

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

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

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

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.

- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

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

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

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends under Coverage for a Disabled Dependent Child*.

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

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

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

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

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

Designated Provider - a provider and/or facility that:

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

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

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

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

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

Emergency - the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

- That the absence of immediate medical attention for an individual could reasonably be expected to result in:
 - Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;
 - Serious impairment of a bodily function; or
 - Serious dysfunction of any organ or body part; or
- With respect to a pregnant woman who is having contractions, that there is:
 - Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or
 - A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital.

Emergency Health Care Services - health care item or service furnished or required to evaluate and treat an Emergency medical condition that is provided in an Emergency facility or setting as follows:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act (42 U.S.C. 1395dd(e)(3))*.

- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

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

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

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

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and

- You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

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

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

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

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

Medically Necessary - Medically Necessary health care means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating and 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, service site and duration.
- Demonstrated through scientific evidence to be effective in improving health outcomes.
- Representative of "best practices" in the medical profession.
- Not primarily for the convenience of the enrollee or Physician or other health care practitioner.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from

time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

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

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

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

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

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

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

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

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

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

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Nurse - an individual who qualifies under the terminology in accordance with Maine statutes or administrative rules of the licensing or registry board of the state.

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

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

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

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

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, certified Nurse practitioner, physician assistant, certified midwife, 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, certified registered Nurse anesthetist, ophthalmologist, acupuncturist, naturopath, 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 Group that includes all of the following:

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

Private Duty Nursing - nursing 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:

- Services exceed the scope of Intermittent Care in the home.
- 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.
- 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.

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

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

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

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

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

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

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

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

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (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.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L.116-260)*.

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

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

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

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

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

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

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

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

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

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

Telehealth - the use of information technology and includes synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring. "Store and forward transfers" means transmission of an enrollee's recorded health history through a secure electronic system to a provider. "Asynchronous encounters" means the interaction or consultation between an enrollee and the enrollee's provider or between providers regarding the enrollee through a system with the ability to store digital information, including, but not limited to, still images, video, audio and text files, and other relevant data in one location and subsequently transmit such information for interpretation at a remote site by health professionals without requiring the simultaneous presence of the patient or the health professionals. "Synchronous encounters" means a real-time interaction conducted with interactive audio or video connection between an enrollee and the enrollee's provider or between providers regarding the enrollee. "Telemonitoring," as it pertains to the delivery of health care services, means the use of information technology to remotely monitor an enrollee's health status via electronic means allowing the provider to track the enrollee's health data over time. Telemonitoring may be synchronous or asynchronous. Telehealth does not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services*.

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, as a result of covered Sickness or Accident, to engage in any employment or occupation for which he or she becomes qualified by reason of education, training or experience and is not engaged in any employment or occupation for wage or profit; 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 Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, and are either:

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

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

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

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

Please note:

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

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

Section 10: Travel and Lodging Program

The *Travel and Lodging Program* provides a Covered Person with a travel and lodging allowance related to the Covered Health Care Service that is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible.

This program provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Service.

This program provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to \$2,000 per Covered Person per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Care Service. Lodging expenses are further limited to \$50 per night for the Covered Person, or \$100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding the *Travel and Lodging Program*, you may contact us at www.myuhc.com or the telephone number on your identification (ID) card.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

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

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a year basis.

Out-of-Pocket Limits are calculated on a year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.</p> <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Annual Deductible does not include any charges for non-Covered Health Care Services.</p>	<p>Network \$4,750 per Covered Person, not to exceed \$9,500 for all Covered Persons in a family.</p> <p>Out-of-Network \$10,000 per Covered Person, not to exceed \$20,000 for all Covered Persons in a family.</p>

Payment Term And Description	Amounts
Out-of-Pocket Limit	
<p>The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, when applicable. <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.</p>	<p>Network</p> <p>\$9,100 per Covered Person, not to exceed \$18,200 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p> <p>Out-of-Network</p> <p>\$20,000 per Covered Person, not to exceed \$40,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p>
Co-payment	
<p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Co-insurance	
<p>Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
-----------------------------	---	---	-----------------------------------

1. Ambulance Services

Prior Authorization Requirement

In most cases, we will initiate and direct non-Emergency ambulance transportation.

For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network <i>Ground Ambulance</i> 30%	Yes	Yes
	<i>Air Ambulance</i> 30%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network <i>Ground Ambulance</i> 30%	Yes	Yes
	<i>Air Ambulance</i> 30%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network Ground Ambulance 50% Air Ambulance Same as Network	Yes Same as Network	Yes Same as Network

2. Autism Spectrum Disorder Treatment

	Network \$40 per visit	Yes	No
	Out-of-Network 20%	Yes	Yes

3. Cellular and Gene Therapy

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
4. Children's Early Intervention Services			
	<p>Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p>Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
5. Clinical Trials			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p>			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	<p>Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p>Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
6. Congenital Heart Disease (CHD) Surgeries			
<p style="text-align: center;">Prior Authorization Requirement</p>			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
-----------------------------	--	---	-----------------------------------

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

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.

Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	<p>Network</p> <p>Benefits will be the same as stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>
--	--

	<p>Out-of-Network</p> <p>Benefits will be the same as stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>
--	---

7. Dental Anesthesia Services

Prior Authorization Requirement

For Network and Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500

	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>
--	---

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			

8. Dental Services - Accident Only			
	<p>Network 30%</p>	Yes	Yes
	<p>Out-of-Network Same as Network</p>	Same as Network	Same as Network

9. Diabetes Services

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

<p>Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care</p> <p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for details.</p> <ul style="list-style-type: none"> • Foot care for systemic circulatory disease. • Nutritional therapy. 	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>
	<p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> .	Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
10. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.			
To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
11. Emergency Health Care Services - Outpatient			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you knowingly elect to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service.</p> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under <i>Hospital - Inpatient Stay</i> will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.</p> <p>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p>	<p>Network 30%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Out-of-Network Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
<p>12. Enteral Nutrition</p>			
	<p>Network</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

13. Family Planning			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

14. Fertility Preservation for Iatrogenic Infertility			
<p>Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p>			

<p>Limited to \$20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as and combined with those stated under <i>Preimplantation Genetic Testing (PGT) and Related Services</i>. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.</p>	<p>Network</p> <p>30%</p>	<p>Yes</p>	<p>Yes</p>
--	----------------------------------	------------	------------

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 50%	Yes	Yes

15. Gender Dysphoria

Prior Authorization Requirement for Surgical Treatment

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Network

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*.

Out-of-Network

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*.

16. Habilitative Services

Prior Authorization Requirement

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
<p>Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility or Skilled Nursing Facility are limited to 150 days per year.</p>	<p>Network <i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefit</i></p>		
<p>Outpatient therapies are limited per year as follows:</p> <ul style="list-style-type: none"> • 60 visits for any combination of physical therapy, occupational therapy and speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive therapy. <p>Benefits for physical therapy, occupational therapy and speech therapy are unlimited for Autism Spectrum Disorder.</p>	<p><i>Outpatient</i> \$40 per visit</p>	<p>Yes</p>	<p>No</p>
<p>Out-of-Network <i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
		<p>Yes</p>	<p>Yes</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20%		

17. Hearing Aids

Limited to a single purchase per hearing impaired ear every 36 months. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	Network 30%	Yes	Yes
---	-----------------------	-----	-----

	Out-of-Network 50%	Yes	Yes
--	------------------------------	-----	-----

18. Home Health Care

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

Services under this category include but are not limited to the following. Please refer to your Certificate for coverage details. • Inhalation therapy. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	Network 30%	Yes	Yes
--	-----------------------	-----	-----

	Out-of-Network 50%	Yes	Yes
--	------------------------------	-----	-----

19. Hospice Care

Prior Authorization Requirement

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p> <p>In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>			
<p>Services under this category include but are not limited to the following. Please refer to your Certificate for coverage details.</p> <ul style="list-style-type: none"> Hospice respite care. Nutritional counseling. 	<p>Network 30%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Out-of-Network 50%</p>	<p>Yes</p>	<p>Yes</p>
<p>20. Hospital - Inpatient Stay</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
<p>Services under this category include but are not limited to the following. Please refer to your Certificate for coverage details.</p> <ul style="list-style-type: none"> Inhalation therapy. 	<p>Network 30%</p>	<p>Yes</p>	<p>Yes</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 50%	Yes	Yes

21. Infant Formulas

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before obtaining the formula or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500

	Network 30% As stated under the <i>Outpatient Prescription Drug Rider</i>	Yes	Yes
	Out-of-Network 50% As stated under the <i>Outpatient Prescription Drug Rider</i>	Yes	Yes

22. Lab, X-Ray and Diagnostic - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

Lab Testing - Outpatient	Network 30%	Yes	Yes
---------------------------------	-----------------------	-----	-----

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 50%	Yes	Yes
Human Leukocyte Antigen Testing	Network None up to the first \$150 of the Allowed Amount; then covered as stated in Lab Testing - Outpatient	Yes	No
	Out-of-Network 50%	Yes	Yes
Prostate-Specific Antigen Testing	Network None	Yes	No
	Out-of-Network 50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

23. Major Diagnostic and Imaging - Outpatient

Prior Authorization Requirement

For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

	Network		
--	----------------	--	--

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

24. Medical Foods

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before obtaining the medical foods or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500

	Network 30% As stated under the <i>Outpatient Prescription Drug Rider</i>	Yes	Yes
	Out-of-Network 50% As stated under the <i>Outpatient Prescription Drug Rider</i>	Yes	Yes

25. Mental Health Care and Substance-Related and Addictive Disorders Services

Prior Authorization Requirement

For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.

In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).</p> <p>If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p>			
<p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details.</p> <ul style="list-style-type: none"> • Detoxification. 	<p>Network</p> <p><i>Inpatient</i> 30%</p> <p><i>Outpatient</i> None for the first visit in a year; \$NaN for any subsequent visits in that year</p> <p>30% for Partial Hospitalization/Intensive Outpatient Treatment</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>No, for the first visit in a year</p> <p>No, for any subsequent visit in a year but Co-payment will apply towards the Annual Deductible</p> <p>Yes</p> <p>Yes</p>
	<p>Out-of-Network</p> <p><i>Inpatient</i> 50%</p> <p><i>Outpatient</i> 50% for Partial Hospitalization/Intensive</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>null</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Outpatient Treatment	Yes	Yes

26. Obesity - Weight Loss Surgery

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity-weight loss surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

It is important that you notify us 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.

	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

27. Ostomy Supplies

Limited to \$2,500 per year.

	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

28. Parenteral and Enteral Therapy

	Network 30%	Yes	Yes
	Out-of-Network		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	50%	Yes	Yes
29. Pharmaceutical Products - Outpatient			
	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
30. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
31. Physician's Office Services - Sickness and Injury			
Services under this category include but are not limited to the following. Please refer to your Certificate for coverage details. <ul style="list-style-type: none"> • Prostate cancer screening. • Allergy testing. 	Network None for the first visit in a year; \$NaN for any subsequent visits in that year for a Primary Care Physician office visit; \$85 for a Specialist office visit	Yes	No, for the first visit in a year No, for any subsequent visit in a year but Co-payment will apply towards the Annual Deductible

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network	Yes	null

32. Pregnancy - Maternity Services

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>
	<p>Out-of-Network</p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>

33. Preimplantation Genetic Testing (PGT) and Related Services

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p>			
<p>Benefit limits for related services will be the same as, and combined with, those stated under <i>Fertility Preservation for Iatrogenic Infertility</i>. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</p> <p>This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i>.</p>	<p>Network 30%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Out-of-Network 50%</p>	<p>Yes</p>	<p>Yes</p>
<p>34. Preventive Care Services</p>			
<p>Physician office services</p> <p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details.</p> <ul style="list-style-type: none"> • Mammogram screening. • Annual gynecological exam. • Pap test. 	<p>Network None</p>	<p>Yes</p>	<p>No</p>
	<p>Out-of-Network 20%</p>	<p>Yes</p>	<p>Yes</p>
<p>Lab, X-ray or other preventive tests</p>	<p>Network</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	None	Yes	No
	Out-of-Network 20%	Yes	Yes
Breast pumps	Network None	Yes	No
	Out-of-Network 20%	Yes	Yes

35. Prosthetic Devices

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

	Network 20% for prosthetic devices to replace an arm or leg and 30% for all other prosthetic devices	Yes	Yes
	Out-of-Network 50%	Yes	Yes

36. Reconstructive Procedures

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
-----------------------------	--	---	-----------------------------------

not exceed \$500.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.

<p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details.</p> <ul style="list-style-type: none"> • Breast reduction. • Varicose veins (symptomatic). • Reconstructive services for birth defects. 	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>
--	---

	<p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>
--	--

37. Rehabilitation Services - Outpatient Therapy

<p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details.</p> <ul style="list-style-type: none"> • Inhalation therapy. • Massage therapy. <p>Limited per year as follows:</p> <ul style="list-style-type: none"> • 60 visits for any combination of physical therapy, occupational therapy and speech therapy. • 30 visits of post-cochlear implant aural therapy. 	<p>Network</p> <p>\$40 per visit</p>	<p>Yes</p>	<p>No</p>
--	---	------------	-----------

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<ul style="list-style-type: none"> 20 visits of cognitive rehabilitation therapy. 			
	Out-of-Network 20%	Yes	Yes
38. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details. <ul style="list-style-type: none"> Colorectal cancer screening. 	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
39. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
Limited to 150 days per year.	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
40. Smoking Cessation			
Limited to: <ul style="list-style-type: none"> • 2 Physician Office Visits per calendar year. • Up to \$35 per Smoking Cessation Program. 	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
41. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.			
Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details. <ul style="list-style-type: none"> • Ambulatory surgery centers. • Blood transfusions. 	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
42. Therapeutic, Adjustive and Manipulative Services			
<p>The below limits apply separately, when applicable, for rehabilitative and habilitative services.</p> <p>Any combination of Network and Out-of-Network Benefits for therapeutic, adjustive and manipulative services is limited to 40 visits per year.</p>	<p>Network \$40 per visit</p>	<p>Yes</p>	<p>No</p>
	<p>Out-of-Network 20%</p>	<p>Yes</p>	<p>Yes</p>
43. Therapeutic Treatments - Outpatient			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.</p>			
<p>Services under this category include but are not limited to the following. Please refer to your <i>Certificate</i> for coverage details.</p> <ul style="list-style-type: none"> • Chemotherapy. • Infusion therapy. • Colorectal cancer screening. 	<p>Network 30%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Out-of-Network 50%</p>	<p>Yes</p>	<p>Yes</p>
44. Transplantation Services			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
-----------------------------	--	---	-----------------------------------

Prior Authorization Requirement

For Out-of-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 do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however the amount of the increase will not exceed \$500.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Services under this category include but are not limited to the following. Please refer to your *Certificate* for coverage details.

- Organ/tissue transplants.

For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.

Network

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

Out-of-Network

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

45. Urgent Care Center Services

Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center:

- Lab, radiology/X-rays and other diagnostic services described

Network

\$85 per visit

Yes

No

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>under <i>Lab, X-Ray and Diagnostic -Outpatient</i>.</p> <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 			
	Out-of-Network 20%	Yes	Yes
46. Urinary Catheters			
	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
47. Virtual Care Services			
Network Benefits are available only	Network		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	Yes	No
	Out-of-Network 20%	Yes	Yes
48. Vision Correction after Surgery or Accident			
	Network Benefits will be the same as those stated under the <i>Durable Medical Equipment</i> category in this <i>Schedule of Benefits</i> .		
	Out-of-Network Benefits will be the same as those stated under the <i>Durable Medical Equipment</i> category in this <i>Schedule of Benefits</i> .		

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.
 - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.
 - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who***

have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- For Covered Health Care Services that are **Emergency Health Care Services provided by an out-of-Network provider**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.
- For Covered Health Care Services that are **Air Ambulance services provided by an out-of-Network provider**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Certificate*. You may determine the maximum allowable charge permitted for a specific service by calling the telephone number on your ID card.

Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment, or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center as described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and

an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency ground ambulance transportation provided by an out-of-Network provider**, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates, or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
 - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - ◆ 50% of *CMS* for the same or similar freestanding laboratory service.
 - ◆ 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
 - ◆ 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.

- When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ◆ For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - ◆ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
 - ◆ When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
 - ◆ When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the *Public Health Service Act*.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's

contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or at the number shown on your ID card.

UnitedHealthcare Insurance Company



Jessica Paik, President

Virtual Behavioral Health Therapy and Coaching Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.

UnitedHealthcare Insurance Company



Jessica Paik, President

UnitedHealthcare Rewards Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards wellness program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health Savings Account (HSA)* or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 or more steps per day	You can earn rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Health-Related Actions and/or Activities	One or more actions and/or activities defined by us and aimed at the following: <ul style="list-style-type: none"> • Health education; • Improving health; or • Maintaining health 	

You may access your actions and/or activity tracking and rewards on the mobile application or www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to a *Health Savings Account (HSA)* or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.

UnitedHealthcare Insurance Company

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik, President

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

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*.

UnitedHealthcare Insurance Company



Jessica Paik, President

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an out-of-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from out-of-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. You may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service that is greater than the Usual and Customary fee. When you obtain Covered Dental Services from out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

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

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

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

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 given a Benefit based on the least costly procedure.
- D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* of this Rider.

Network Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary 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.

Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amount.

Annual Deductible

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

Out-of-Pocket Limit - any amount you pay in Co-insurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Benefits

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

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

Benefit Description

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<i>Diagnostic Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
<p><i>Evaluations (Checkup Exams)</i></p> <p>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.</p> <p>D0120 - Periodic oral evaluation.</p> <p>D0140 - Limited oral evaluation - problem focused.</p> <p>D9995 - Teledentistry - synchronous - real time encounter.</p> <p>D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review.</p> <p>D0150 - Comprehensive oral evaluation - new or established patient.</p> <p>D0180 - Comprehensive periodontal evaluation - new or established patient.</p> <p>The following service is not subject to a frequency limit.</p> <p>D0160 - Detailed and extensive oral evaluation - problem focused, by report.</p>	None	20%
<p><i>Intraoral Radiographs (X-ray)</i></p> <p>Limited to 2 series of films per 12 months.</p> <p>D0210 - Intraoral - complete series of radiographic images.</p> <p>D0709 - Intraoral - complete series of radiographic images -</p>	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
image capture only.		
<p>The following services are not subject to a frequency limit.</p> <p>D0220 - Intraoral - periapical first radiographic image.</p> <p>D0230 - Intraoral - periapical - each additional radiographic image.</p> <p>D0240 - Intraoral - occlusal radiographic image.</p> <p>D0706 - Intraoral - occlusal radiographic image - image capture only.</p> <p>D0707 - Intraoral - periapical radiographic image - image capture only.</p>	None	20%
<p>Any combination of the following services is limited to 2 series of films per 12 months.</p> <p>D0270 - Bitewing - single radiographic image.</p> <p>D0272 - Bitewings - two radiographic images.</p> <p>D0274 - Bitewings - four radiographic images.</p> <p>D0277 - Vertical bitewings - 7 to 8 radiographic images.</p> <p>D0708 - Intraoral - bitewing radiographic image - image capture only.</p>	None	20%
<p>Limited to 1 time per 36 months.</p> <p>D0330 - Panoramic radiograph image.</p> <p>D0701 - Panoramic radiographic image - image capture only.</p> <p>D0702 - 2-D Cephalometric radiographic image - image</p>	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
capture only. D0704 - 3-D Photographic image - image capture only.		
The following services are limited to two images per calendar year. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None	20%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis. D0350 - 2-D Oral/facial photographic images obtained intra-orally or extra-orally. D0470 - Diagnostic casts. D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None	20%
Preventive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
<i>Dental Prophylaxis (Cleanings)</i> The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult. D1120 - Prophylaxis - child.	None	20%
<i>Fluoride Treatments</i> The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish. D1208 - Topical application of fluoride - excluding varnish.	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p><i>Sealants (Protective Coating)</i></p> <p>The following services are limited to once per first or second permanent molar every 36 months.</p> <p>D1351 - Sealant - per tooth.</p> <p>D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth.</p>	None	20%
<p><i>Space Maintainers (Spacers)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D1510 - Space maintainer - fixed, unilateral - per quadrant.</p> <p>D1516 - Space maintainer - fixed - bilateral, maxillary.</p> <p>D1517 - Space maintainer - fixed - bilateral, mandibular.</p> <p>D1520 - Space maintainer - removable, unilateral - per quadrant.</p> <p>D1526 - Space maintainer - removable - bilateral, maxillary.</p> <p>D1527 - Space maintainer - removable - bilateral, mandibular.</p> <p>D1551 - Re-cement or re-bond bilateral space maintainer - maxillary.</p> <p>D1552 - Re-cement or re-bond bilateral space maintainer - mandibular.</p> <p>D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant.</p> <p>D1556 - Removal of fixed unilateral space maintainer - per quadrant.</p>	None	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.		

Minor Restorative Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)

<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2140 - Amalgams - one surface, primary or permanent.</p> <p>D2150 - Amalgams - two surfaces, primary or permanent.</p> <p>D2160 - Amalgams - three surfaces, primary or permanent.</p> <p>D2161 - Amalgams - four or more surfaces, primary or permanent.</p>	20%	40%
--	-----	-----

<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2330 - Resin-based composite - one surface, anterior.</p> <p>D2331 - Resin-based composite - two surfaces, anterior.</p> <p>D2332 - Resin-based composite - three surfaces, anterior.</p> <p>D2335 - Resin-based composite - four or more surfaces or involving incisal angle, (anterior).</p>	20%	40%
--	-----	-----

Crowns/Inlays/Onlays - Network and Out-of-Network (Subject to payment of the Annual Deductible.)

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>The following services are subject to a limit of one time every 60 months.</p> <p>D2542 - Onlay - metallic - two surfaces.</p> <p>D2543 - Onlay - metallic - three surfaces.</p> <p>D2544 - Onlay - metallic - four or more surfaces.</p> <p>D2740 - Crown - porcelain/ceramic.</p> <p>D2750 - Crown - porcelain fused to high noble metal.</p> <p>D2751 - Crown - porcelain fused to predominately base metal.</p> <p>D2752 - Crown - porcelain fused to noble metal.</p> <p>D2753 - Crown - porcelain fused to titanium and titanium alloys.</p> <p>D2780 - Crown - 3/4 cast high noble metal.</p> <p>D2781 - Crown - 3/4 cast predominately base metal.</p> <p>D2783 - Crown - 3/4 porcelain/ceramic.</p> <p>D2790 - Crown - full cast high noble metal.</p> <p>D2791 - Crown - full cast predominately base metal.</p> <p>D2792 - Crown - full cast noble metal.</p> <p>D2794 - Crown - titanium and titanium alloys.</p> <p>D2930 - Prefabricated stainless steel crown - primary tooth.</p> <p>D2931 - Prefabricated stainless steel crown - permanent tooth.</p> <p>The following services are not</p>	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement or re-bond inlay. D2920 - Re-cement or re-bond crown.		
The following service is not subject to a frequency limit. D2940 - Protective restoration.	50%	50%
The following services are limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth. D2950 - Core buildup, including any pins when required.	50%	50%
The following service is limited to one time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to restoration.	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>material failure.</p> <p>D2981 - Inlay repair necessitated by restorative material failure.</p> <p>D2982 - Onlay repair necessitated by restorative material failure.</p>		
<i>Endodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
<p>The following service is not subject to a frequency limit.</p> <p>D3220 - Therapeutic pulpotomy (excluding final restoration).</p>	20%	40%
<p>The following service is not subject to a frequency limit.</p> <p>D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.</p>	20%	40%
<p>The following services are not subject to a frequency limit.</p> <p>D3230 - Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration).</p> <p>D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).</p>	20%	40%
<p>The following services are not subject to a frequency limit.</p> <p>D3310 - Endodontic therapy anterior tooth (excluding final restoration).</p> <p>D3320 - Endodontic therapy, premolar tooth (excluding final restoration).</p> <p>D3330 - Endodontic therapy, molar tooth (excluding final</p>	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - bicuspid. D3348 - Retreatment of previous root canal therapy - molar.		
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement. D3353 - Apexification/recalcification - final visit.	20%	40%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior. D3421 - Apicoectomy - premolar (first root). D3425 - Apicoectomy - molar (first root). D3426 - Apicoectomy (each additional root). D3450 - Root amputation - per root. D3471 - Surgical repair of root resorption - anterior. D3472 - Surgical repair of root resorption - premolar. D3473 - Surgical repair of root resorption - molar. D3501 - Surgical exposure of root	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
surface without apicoectomy or repair of root resorption - anterior. D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.		
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier. D3920 - Hemisection (including any root removal), not including root canal therapy.	20%	40%
<i>Periodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	20%	40%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant. D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. D4249 - Clinical crown	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
lengthening - hard tissue.		
<p>The following services are limited to one every 36 months.</p> <p>D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.</p> <p>D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant.</p> <p>D4263 - Bone replacement graft - retained natural tooth - first site in quadrant.</p>	20%	40%
<p>The following service is not subject to a frequency limit.</p> <p>D4270 - Pedicle soft tissue graft procedure.</p>	20%	40%
<p>The following services are not subject to a frequency limit.</p> <p>D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft.</p> <p>D4275 - Non-autogenous connective tissue graft first tooth implant.</p> <p>D4277 - Free soft tissue graft procedure - first tooth.</p> <p>D4278 - Free soft tissue graft procedure - each additional contiguous tooth.</p> <p>D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns.</p> <p>D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.</p>	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>The following services are limited to one time per quadrant every 24 months.</p> <p>D4341 - Periodontal scaling and root planing - four or more teeth per quadrant.</p> <p>D4342 - Periodontal scaling and root planing - one to three teeth per quadrant.</p> <p>D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.</p>	20%	40%
<p>The following service is limited to a frequency to one per lifetime.</p> <p>D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit.</p>	20%	40%
<p>The following service is limited to four times every 12 months in combination with prophylaxis.</p> <p>D4910 - Periodontal maintenance.</p>	20%	40%
<p><i>Removable Dentures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></p>		
<p>The following services are limited to a frequency of one every 60 months.</p> <p>D5110 - Complete denture - maxillary.</p> <p>D5120 - Complete denture - mandibular.</p> <p>D5130 - Immediate denture - maxillary.</p> <p>D5140 - Immediate denture - mandibular.</p>	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth).</p> <p>D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth).</p> <p>D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).</p> <p>D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).</p> <p>D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth).</p>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth).</p> <p>D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.</p> <p>D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.</p> <p>D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.</p> <p>D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.</p>		
<p>The following services are not subject to a frequency limit.</p> <p>D5410 - Adjust complete denture - maxillary.</p> <p>D5411 - Adjust complete denture - mandibular.</p> <p>D5421 - Adjust partial denture - maxillary.</p> <p>D5422 - Adjust partial denture - mandibular.</p> <p>D5511 - Repair broken complete denture base - mandibular.</p> <p>D5512 - Repair broken complete denture base - maxillary.</p> <p>D5520 - Replace missing or broken teeth - complete denture</p>	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>(each tooth).</p> <p>D5611 - Repair resin partial denture base - mandibular.</p> <p>D5612 - Repair resin partial denture base - maxillary.</p> <p>D5621 - Repair cast partial framework - mandibular.</p> <p>D5622 - Repair cast partial framework - maxillary.</p> <p>D5630 - Repair or replace broken retentive/clasping materials - per tooth.</p> <p>D5640 - Replace broken teeth - per tooth.</p> <p>D5650 - Add tooth to existing partial denture.</p> <p>D5660 - Add clasp to existing partial denture.</p>		
<p>The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months.</p> <p>D5710 - Rebase complete maxillary denture.</p> <p>D5711 - Rebase complete mandibular denture.</p> <p>D5720 - Rebase maxillary partial denture.</p> <p>D5721 - Rebase mandibular partial denture.</p> <p>D5725 - Rebase hybrid prosthesis.</p> <p>D5730 - Reline complete maxillary denture (direct).</p> <p>D5731 - Reline complete mandibular denture (direct).</p> <p>D5740 - Reline maxillary partial</p>	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic full denture (per arch).		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%	50%
<i>Bridges (Fixed partial dentures (FPD)) - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic - titanium and titanium alloys. D6240 - Pontic - porcelain fused to high noble metal. D6241 - Pontic - porcelain fused	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>to predominately base metal.</p> <p>D6242 - Pontic - porcelain fused to noble metal.</p> <p>D6243 - Pontic - porcelain fused to titanium and titanium alloys.</p> <p>D6245 - Pontic - porcelain/ceramic.</p>		
<p>The following services are not subject to a frequency limit.</p> <p>D6545 - Retainer - cast metal for resin bonded fixed prosthesis.</p> <p>D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.</p>	50%	50%
<p>The following services are limited to one time every 60 months.</p> <p>D6740 - Retainer crown - porcelain/ceramic.</p> <p>D6750 - Retainer crown - porcelain fused to high noble metal.</p> <p>D6751 - Retainer crown - porcelain fused to predominately base metal.</p> <p>D6752 - Retainer crown - porcelain fused to noble metal.</p> <p>D6753 - Retainer crown - porcelain fused to titanium and titanium alloys.</p> <p>D6780 - Retainer crown - 3/4 cast high noble metal.</p> <p>D6781 - Retainer crown - 3/4 cast predominately base metal.</p> <p>D6782 - Retainer crown - 3/4 cast noble metal.</p> <p>D6783 - Retainer crown - 3/4 porcelain/ceramic.</p>	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
D6784 - Retainer crown - 3/4 titanium and titanium alloys. D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD.	50%	50%
The following services are not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure.	50%	50%
<i>Oral Surgery - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root.	20%	40%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony. D7241 - Removal of impacted tooth - completely bony with	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>unusual surgical complications.</p> <p>D7250 - Surgical removal or residual tooth roots.</p> <p>D7251 - Coronectomy - intentional partial tooth removal.</p>		
<p>The following service is not subject to a frequency limit.</p> <p>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.</p>	20%	40%
<p>The following service is not subject to a frequency limit.</p> <p>D7280 - Surgical access exposure of an unerupted tooth.</p>	20%	40%
<p>The following services are not subject to a frequency limit.</p> <p>D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.</p> <p>D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant.</p> <p>D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.</p> <p>D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant.</p>	20%	40%
<p>The following service is not subject to a frequency limit.</p> <p>D7471 - removal of lateral exostosis (maxilla or mandible).</p>	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>The following services are not subject to a frequency limit.</p> <p>D7510 - Incision and drainage of abscess, intraoral soft tissue.</p> <p>D7910 - Suture of recent small wounds up to 5 cm.</p> <p>D7953 - Bone replacement graft for ridge preservation - per site.</p> <p>D7961 - Buccal/labial frenectomy (frenulectomy).</p> <p>D7962 - Lingual frenectomy (frenulectomy).</p> <p>D7971 - Excision of pericoronal gingiva.</p>	20%	40%
<p><i>Adjunctive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></p>		
<p>The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.</p> <p>D9110 - Palliative (Emergency) treatment of dental pain - minor procedure.</p>	20%	40%
<p>Covered only when clinically Necessary.</p> <p>D9222 - Deep sedation/general anesthesia - first 15 minutes.</p> <p>D9223 - Deep sedation/general anesthesia - each 15 minute increment.</p> <p>D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes.</p> <p>D9610 - Therapeutic parenteral</p>	20%	40%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
drug single administration.		
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	20%	40%
The following is limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch. D9945 - Occlusal guard - soft appliance, full arch. D9946 - Occlusal guard - hard appliance, partial arch.	20%	40%
The following services are not subject to a frequency limit. D9930 - Treatment of complications (post-surgical) - unusual circumstances, by report.	20%	40%
<i>Implant Procedures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i>		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Surgical placement of eosteal implant. D6050 - Surgical placement: transosteal implant. D6055 - Connecting bar - implant supported or abutment supported. D6056 - Prefabricated abutment - includes modification and	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>placement.</p> <p>D6057 - Custom fabricated abutment - includes placement.</p> <p>D6058 - Abutment supported porcelain/ceramic crown.</p> <p>D6059 - Abutment supported porcelain fused to metal crown (high noble metal).</p> <p>D6060 - Abutment supported porcelain fused to metal crown (predominately base metal).</p> <p>D6061 - Abutment supported porcelain fused to metal crown (noble metal).</p> <p>D6062 - Abutment supported cast metal crown (high noble metal).</p> <p>D6063 - Abutment supported cast metal crown (predominately base metal).</p> <p>D6064 - Abutment supported cast metal crown (noble metal).</p> <p>D6065 - Implant supported porcelain/ceramic crown.</p> <p>D6066 - Implant supported crown - porcelain fused to high noble alloys.</p> <p>D6067 - Implant supported crown - high noble alloys.</p> <p>D6068 - Abutment supported retainer for porcelain/ceramic FPD.</p> <p>D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal).</p> <p>D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal).</p> <p>D6071 - Abutment supported</p>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>retainer for porcelain fused to metal FPD (noble metal).</p> <p>D6072 - Abutment supported retainer for cast metal FPD (high noble metal).</p> <p>D6073 - Abutment supported retainer for cast metal FPD (predominately base metal).</p> <p>D6074 - Abutment supported retainer for cast metal FPD (noble metal).</p> <p>D6075 - Implant supported retainer for ceramic FPD.</p> <p>D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys.</p> <p>D6077 - Implant supported retainer for metal FPD - high noble alloys.</p> <p>D6080 - Implant maintenance procedure.</p> <p>D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.</p> <p>D6082 - Implant supported crown - porcelain fused to predominantly base alloys.</p> <p>D6083 - Implant supported crown - porcelain fused to noble alloys.</p> <p>D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys.</p> <p>D6086 - Implant supported crown - predominantly base alloys.</p> <p>D6087 - Implant supported crown - noble alloys.</p> <p>D6088 - Implant supported crown</p>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>- titanium and titanium alloys.</p> <p>D6090 - Repair implant supported prosthesis, by report.</p> <p>D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.</p> <p>D6095 - Repair implant abutment, by report.</p> <p>D6096 - Remove broken implant retaining screw.</p> <p>D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys.</p> <p>D6098 - Implant supported retainer - porcelain fused to predominantly base alloys.</p> <p>D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys.</p> <p>D6100 - Surgical removal of implant body.</p> <p>D6101 - Debridement peri-implant defect.</p> <p>D6102 - Debridement and osseous contouring of a peri-implant defect.</p> <p>D6103 - Bone graft for repair peri-implant defect.</p> <p>D6104 - Bone graft at time of implant replacement.</p> <p>D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular.</p> <p>D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary.</p> <p>D6120 - Implant supported</p>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>retainer - porcelain fused to titanium and titanium alloys.</p> <p>D6121 - Implant supported retainer for metal FPD - predominantly base alloys.</p> <p>D6122 - Implant supported retainer for metal FPD - noble alloys.</p> <p>D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys.</p> <p>D6190 - Radiographic/surgical implant index, by report.</p> <p>D6191 - Semi-precision abutment - placement.</p> <p>D6192 - Semi-precision attachment - placement.</p> <p>D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.</p>		
<p><i>Medically Necessary Orthodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></p> <p>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, <i>Crouzon's Syndrome</i>, <i>Treacher-Collins Syndrome</i>, <i>Pierre-Robin Syndrome</i>, 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 (<i>TMJ</i>) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>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.</p> <p>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.</p>		
<p>The following services are not subject to a frequency limitation as long as benefits have been</p>	<p>50%</p>	<p>50%</p>

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>prior authorized.</p> <p>D8010 - Limited orthodontic treatment of the primary dentition.</p> <p>D8020 - Limited orthodontic treatment of the transitional dentition.</p> <p>D8030 - Limited orthodontic treatment of the adolescent dentition.</p> <p>D8070 - Comprehensive orthodontic treatment of the transitional dentition.</p> <p>D8080 - Comprehensive orthodontic treatment of the adolescent dentition.</p> <p>D8210 - Removable appliance therapy.</p> <p>D8220 - Fixed appliance therapy.</p> <p>D8660 - Pre-orthodontic treatment visit.</p> <p>D8670 - Periodic orthodontic treatment visit.</p> <p>D8680 - Orthodontic retention.</p> <p>D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment.</p> <p>D8696 - Repair of orthodontic appliance - maxillary.</p> <p>D8697 - Repair of orthodontic appliance - mandibular.</p> <p>D8698 - Re-cement or re-bond fixed retainer - maxillary.</p> <p>D8699 - Re-cement or re-bond fixed retainer - mandibular.</p> <p>D8701 - Repair of fixed retainer, includes reattachment - maxillary.</p> <p>D8702 - Repair of fixed retainer,</p>		

Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
includes reattachment - mandibular.		

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Pediatric 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 Pediatric 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 related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly related 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, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment related 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 not keeping 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 provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends.
17. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
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 receiving Dental Services from an out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information shown below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services provided before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.

- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

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*:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Allowed Dental Amounts are our contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Allowed Dental Amounts are the Usual and Customary fees, as defined below.

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 provide Dental Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Services and supplies under this 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.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - ♦ For treating a life threatening dental disease or condition.
 - ♦ Provided in a clinically controlled research setting.
 - ♦ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this 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 used 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

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

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*.

UnitedHealthcare Insurance Company



Jessica Paik, President

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network or out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek payment from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this *Rider* under *Section 3: Claims for Pediatric Vision Care Services*. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*. Any amount you pay in Co-payments for Vision Care Services under this Rider applies to the Out-of-Pocket Limit 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* unless otherwise specifically stated. Any amount you pay in Co-payments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits*.

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-payments and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Exam

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.

- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
 - A comprehensive exam of visual functions.
 - The prescription of corrective eyewear or vision aids where indicated.
 - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
<i>Routine Vision Exam or Refraction only in lieu of a complete exam</i>	Once every 12 months.	\$30 per exam. Not subject to payment of the Annual Deductible.	20% of the billed charge.
<i>Eyeglass Lenses</i>	Once every 12 months.		
• Single Vision		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Bifocal		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Trifocal		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Lenticular		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
<i>Lens Extras</i>			
• Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
• Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
<i>Eyeglass Frames</i>	Once every 12 months.		
• Eyeglass frames with a retail cost up to \$130.		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - 160.		50% Not subject to payment	50% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
		of the Annual Deductible.	
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost of \$160 - 200. 		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost of \$200 -250. 		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> • Eyeglass frames with a retail cost greater than \$250. 		50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Contact Lenses and Fitting & Evaluation			
<ul style="list-style-type: none"> • Contact Lens Fitting & Evaluation 	Once every 12 months.	None Not subject to payment of the Annual Deductible.	None
<ul style="list-style-type: none"> • Covered Contact Lens Selection 	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Necessary Contact Lenses	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.	50% of the billed charge.
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months		
<ul style="list-style-type: none"> • Low vision testing 		None	20% of billed charges.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
		Not subject to payment of the Annual Deductible.	
<ul style="list-style-type: none"> • Low vision therapy 		25% of the billed charges. Not subject to payment of the Annual Deductible.	25% of billed charges.

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 Pediatric 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 an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in 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.

Written notice of sickness or injury must be provided to us within 30 days after the date when such sickness or injury occurred. Within 15 days of receipt of such notification we will provide forms for filing proof of loss. 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.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services provided by a non-UnitedHealthcare Vision Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not provided by a UnitedHealthcare Vision Network Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

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 UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this *Rider* in *Section 1: Benefits for Pediatric Vision Care Services*.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the 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 Care Services described in the *Certificate*.



William J Golden, President

Introduction

Coverage Policies and Guidelines

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

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

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

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

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

Notice of Adverse Change to the Prescription Drug List

We will provide at least 60 days' written notice of an adverse change to the Prescription Drug List, less than 60 days' notice is allowed when a drug is being removed from the Prescription Drug List due to safety concerns.

"Adverse change to the Prescription Drug List" means a change that removes a Prescription Drug Product currently prescribed for you from the Prescription Drug List applicable to your health plan or a change that moves the Prescription Drug Product to a tier with a higher cost-sharing requirement.

The notice will inform you of the change and advise you to consult with your provider about the change. If a Prescription Drug Product is removed from the Prescription Drug List, we will notify you of the ability to request an exception and provide a form for requesting the exception.

If you have already received prior authorization for the Prescription Drug Product, we will continue to honor the authorization until it expires, as long as you continue to be covered under the same plan and the Prescription Drug Product has not been removed from the Prescription Drug List due to safety concerns.

If a Prescription Drug Product has been removed from the Prescription Drug List (except if removed due to safety concerns), and an exception request is received prior to the effective date of the change, we will continue to cover the Prescription Drug Product until a decision is reached on the exception request.

Identification Card (ID Card) - Network Pharmacy

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

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

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

Submit your claim to:

Optum Rx
PO Box 650629
Dallas, TX 75265-0629

Designated Pharmacies

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

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

Smart Fill Program - Split Fill

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

Smart Fill Program - 90-Day Supply

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

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require

you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

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

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug 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 or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

Maintenance Medication Program

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

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or 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 six 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 Co-payment, Co-insurance or deductible requirements of the Policy.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products180
Section 2: Exclusions182
Section 3: Defined Terms185
Section 4: Your Right to Request an Exclusion Exception188

Section 1: Benefits for Prescription Drug Products

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

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service

Prescription Drug Products as Part of a Clinical Trial

Benefits are provided for outpatient Prescription Drug Products provided as part of an approved clinical trial if the following conditions are met:

- 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. Refer to *Clinical Trials* in *Section 1: Covered Health Care Services in your Certificate* for details of coverage.

Early Refills of Prescription Eye Drops

Benefits are provided for one early refill of a Prescription Order or Refill for eye drops when the following criteria are met:

- You request the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed.
- The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized.
- The refill requested does not exceed the number of refills indicated on the original Prescription Order or Refill.
- The Prescription Drug Product has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for early refill.
- The prescription eye drops are a covered benefit under the plan.

Your Cost-Sharing responsibility will be based on any applicable Co-payment, Co-insurance or deductible requirements of the Policy.

Abuse-Deterrent Opioid Analgesic Prescription Drug Products

Benefits are provided for Abuse-Deterrent Opioid Analgesic Prescription Drug Products and will be no less favorable than Benefits for opioid analgesic Prescription Drug Products that are not abuse-deterrent and that are covered under this Policy.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that Prescription Drug Products that are refilled at the same frequency can be refilled concurrently. You may access information on these procedures through the Internet at [www.myuhc.com] or by calling the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

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

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

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

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

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

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

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

Section 2: Exclusions

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

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.

This exclusion does not apply to the off-label use of a Prescription Drug Product prescribed to treat cancer, HIV or 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 *Clinical Trials* in *Section 1: Covered Health Care Services* in your *Certificate*.

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 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 includes certain forms of vaccines/immunizations.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.

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

requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

29. Dental products, including but not limited to prescription fluoride topicals.

30. A Prescription Drug Product with either:

- An approved biosimilar.
- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

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

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

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

31. Diagnostic kits and products, including associated services.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Abuse-Deterrent Opioid Analgesic Drug Product - a Brand-name or Generic Opioid Analgesic Drug Product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse.

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

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

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

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

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

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

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

Cost-Sharing - any coverage limit, Co-payment, Co-insurance, deductible or other out-of-pocket expense associated with a health plan.

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

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

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.

- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Opioid Analgesic Drug Product - a Brand-name or generic drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in the immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, such as Human Immunodeficiency Virus (HIV) prevention drugs.
- 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 all *FDA* -approved methods of female contraception, including over the counter products..

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

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

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Oral hypoglycemic agents.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate under Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours or two business days of receipt of the request, whichever is less.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits*, in addition to any applicable Ancillary Charge.

Exigent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours. If coverage approved, we will cover the Prescription Drug Product for the duration of the exigency.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours or two business days of receipt of the request, whichever is less.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

The Prescription Drug List categorizes medications, products or devices that have been approved by the *U.S. Food and Drug Administration* into tiers. The Prescription Drug List is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). Please contact us at [www.myuhc.com] or the telephone number on your ID card for the most up-to-date tier placement.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service

Orally Administered Cancer Therapy

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

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Dispensing an Emergency Supply of Chronic Maintenance Drugs

A pharmacist may dispense an emergency supply of a chronic maintenance drug to a patient without a prescription if the pharmacist is unable to obtain authorization to refill the prescription from a health care provider and the pharmacist has a record of the prescription in the name of the patient, including the amount of the drug dispensed in the most recent prescription or the standard unit of dispensing the drug, and that record does not indicate that no emergency supply is permitted. A pharmacist may dispense an emergency supply of a chronic maintenance drug to a patient as long as the following conditions are met:

- The drug dispensed may not be a controlled substance included in Schedules I and II under the federal *Controlled Substances Act*.
- The amount dispensed may not exceed a 30-day supply or, if the standard unit of dispensing exceeds a 30-day supply, may not exceed the smallest standard unit of dispensing, except that, if the drug is included on Schedule III or IV of the federal *Controlled Substances Act*, the amount dispensed may not exceed a 7-day supply
- The pharmacist may not dispense the chronic maintenance drug in an emergency supply to the same patient more than twice in a 12-month period.
- The pharmacist must determine, in the pharmacist's professional judgment, that the prescription is essential to sustain the life of the patient or to continue therapy for a chronic condition of the patient and that failure to dispense the drug could reasonably produce undesirable health consequences or cause physical or mental discomfort.

"Chronic maintenance drug" means a medication prescribed to treat a chronic, long-term condition and that is taken on a regular, recurring basis.

Prescription Drug Coverage During A State of Emergency

We shall provide coverage for the furnishing or dispensing of a Prescription Drug Product in accordance with a valid prescription issued by a Provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor in accordance with *Title 37-B, section 742*. This does not apply to coverage of prescribed contraceptive supplies furnished and dispensed pursuant to *Section 2756, 2847-G or 4247* or coverage of opioids prescribed in accordance with limits set forth in *Title 32*.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

Prior authorization will not be required for at least one Prescription Drug Product for treatment of opioid use disorder in each therapeutic class of medication used in medication-assisted treatment. Prior authorization will not be required for medication-assisted treatment for opioid use disorder for Covered Persons who are Pregnant.

Prior authorizations will not be denied for Prescription Drug Products on the Prescription Drug List that is prescribed to assess or treat a serious mental illness. A "serious mental illness" means a mental disorder, as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*, that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

We will accept and respond to prior authorization requests through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

Clinical review criteria used to establish a step therapy protocol will be based on clinical practice guidelines that:

- Recommend that the Prescription Drug Products be taken in the specific sequence required by the step therapy protocol.

- Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:
 - Requiring members to disclose any potential conflicts of interest with entities, including carriers and pharmaceutical manufacturers, and recuse themselves from voting if they have a conflict of interest.
 - Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.
 - Offering opportunities for public review and comments.
- Are based on high-quality studies, research and medical practice.
- Are created by an explicit and transparent process that:
 - Minimizes biases and conflicts of interest.
 - Explains the relationship between treatment options and outcomes.
 - Rates the quality of the evidence supporting recommendations.
 - Considers relevant patient subgroups and preferences.
 - Are continually updated through a review of new evidence, research and newly developed treatments.

In the absence of clinical practice guidelines that meet the above requirements, peer-reviewed publications may be substituted.

Prescription Drug Products on the Prescription Drug List that are prescribed to assess or treat a serious mental illness will be approved. Prescription Drugs on the Prescription Drug List that are prescribed for a serious mental illness will not require Step Therapy.

Exceptions process. When coverage of a Prescription Drug Product for the treatment of any medical condition is restricted for use by us or a utilization review organization through the use of a step therapy protocol, the Covered Person and the prescriber must have access to a clear, readily accessible and convenient process to request a step therapy override exception determination from us or the utilization review organization.

- We or the utilization review organization may use the existing medical exceptions process to provide step therapy override exception determinations, and the process established must be easily accessible on our or the utilization review organization's website.
- We or the utilization review organization shall expeditiously grant a step therapy override exception determination if:
 - The required prescription drug is contraindicated or will likely cause an adverse reaction in or physical or mental harm to the Covered Person.
 - The required Prescription Drug Product is expected to be ineffective based on the known clinical characteristics of the Covered Person and the known characteristics of the Prescription Drug Product regimen.
 - The Covered Person has tried the required Prescription Drug Product while under the Covered Person's current or previous health insurance or health plan, or another Prescription Drug Product in the same pharmacologic class or with the same mechanism of action, and the Prescription Drug Product was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse reaction.
 - The required Prescription Drug Product is not in the best interest of the Covered Person, based on Medical Necessity.

- The Covered Person is stable on a Prescription Drug Product selected by the Covered Person's health care provider for the medical condition under consideration while on a current or previous health insurance or health plan.

Nothing in this paragraph may be construed to encourage the use of a pharmaceutical sample for the sole purpose of meeting the requirements for the granting of a step therapy override exception determination.

- Upon the granting of a step therapy override exception determination, we or the utilization review organization shall authorize coverage for the Prescription Drug Product prescribed by the prescriber.
- Unless exigent circumstances exist, we or the utilization review organization shall grant or deny a request for a step therapy override exception determination or an appeal of a determination within 72 hours, or 2 business days, whichever is less, after receipt of the request.

If exigent circumstances exist, we or the utilization review organization shall grant or deny the request within 24 hours after receipt of the request. We shall provide coverage for the Prescription Drug Product prescribed by the prescriber during the pendency of the request for a step therapy override exception determination or an appeal of a determination. If we or the utilization review organization do not grant or deny the request within the time required under this paragraph, the exception or appeal is granted.

Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

- A Covered Person may appeal a step therapy override exception determination.
- This section does not prevent:
 - Us or the utilization review organization from requiring a Covered Person to try a generic drug, as defined in 32 M.R.S. § 13702-A(14), or an interchangeable biological product, as defined in 32 M.R.S. § 13702-A(14-A), prior to providing coverage for the equivalent brand-name Prescription Drug Product.
 - A health care provider from prescribing a Prescription Drug Product that is determined to be Medically Necessary.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

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

- Ancillary Charges.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.

- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit	
<p>The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.</p>	<p>\$5,000 per Covered Person.</p>
Co-payment and Co-insurance	
<p>Co-payment</p> <p>Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount.</p> <p>Co-insurance</p> <p>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.</p> <p>Co-payment and Co-insurance</p> <p>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law.</p> <p>For insulin Prescription Drug Products on any tier, the total amount of deductibles, Co-payments, Co-insurance or other cost sharing requirements shall not exceed \$35 per prescription up to a 30-day supply, regardless of the amount of insulin needed to fill your insulin prescriptions.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Co-payment/Co-insurance 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 Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.</p> <p>Prescription Drug Products Prescribed by a Specialist: You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.</p>	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>Specialty Prescription Drug Products</p>	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>We designate certain Network Pharmacies to be Preferred Specialty Network Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at www.myuhc.com or by the telephone number on your ID card.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement.</p> <p>Preferred Specialty Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: \$15 per Prescription Order or Refill.</p> <p>For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$60 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: \$600 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<p>If you choose to obtain your Specialty Prescription</p>	<p>Non-Preferred Specialty Network Pharmacy</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>You will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.</p> <p>Out-of-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: \$15 per Prescription Order or Refill.</p> <p>For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$60 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: \$600 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> 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 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>based on supply limits.</p> <ul style="list-style-type: none"> A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. You may also receive up to a 12-month cycle of the same contraceptive for subsequent dispensing at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied, when the prescriber writes the script to fill a 12-month fill. <p>Benefits for contraceptive supplies will be provided without application of Deductibles, Co-payments, Co-insurance or other cost-sharing requirement. If the <i>U.S. Food and Drug Administration (FDA)</i> has approved one or more therapeutic equivalent of a contraceptive supply, at least one will be covered without the application of Deductibles, Co-payments, Co-insurance or other cost-sharing.</p> <p>Benefits will be provided without application of Deductible, Co-payments and/or Co-insurance for at least one HIV prevention drug within each method of administration.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p>	<p>4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: \$15 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$60 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Out-of-Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> 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 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>based on supply limits.</p> <ul style="list-style-type: none"> A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. You may also receive up to a 12-month cycle of the same contraceptive for subsequent dispensing at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied, when the prescriber writes the script to fill a 12-month fill. <p>Benefits will be provided without application of Deductibles, Co-payments and/or Co-insurance for at least one contraceptive supply within each method of contraception.</p> <p>Benefits will be provided without application of Deductible, Co-payments and/or Co-insurance for at least one HIV prevention drug within each method of administration.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p>	<p>Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: \$15 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$60 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<p>Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> 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 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</p> <p>You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p> <p>For insulin Prescription Drug Products on any tier, the total amount of deductibles, Co-payments, Co-insurance or other cost sharing requirements shall not exceed \$35 per prescription up to a 30-day supply; \$70 per prescription up to a 60-day supply; \$105 per prescription up to a 90-day supply per regardless of the amount of insulin needed to fill your insulin prescriptions.</p>	<p>telephone number on your ID card to find out tier status.</p> <p>For up to a 31-day supply at a mail order Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$15 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$60 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For up to a 60-day supply at a mail order Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$30 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$120 per Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	<p>What Is the Co-payment or Co-insurance You Pay?</p> <p>This May Include a Co-payment, Co-insurance or Both</p>
	<p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$600 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$37.50 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$150 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$375 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$750 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
	<p>Preventive Medications: \$12.50 per Prescription Order or Refill.</p>