UnitedHealthcare of Texas, Inc.

Individual Exchange Benefit Plan
Evidence of Coverage

1311 W. President George Bush Highway

Richardson, TX 75080

1-866-811-2704

www.myuhc.com/exchange

Contract Number - [999-999-999]

Subscriber - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

THE CONTRACT UNDER WHICH THIS EVIDENCE OF COVERAGE IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Agreement and Consideration

We will pay Benefits as set forth in this Evidence of Coverage (EOC). This EOC is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this EOC, except that your coverage may end for events as described in this EOC, *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This EOC will renew on January 1 of each calendar year. On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product. In addition, we may make modifications at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

On January 1 of each calendar year, we may change the rate table used for this EOC. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are this EOC plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

Nothing in this section requires us to renew or continue coverage for which your continued eligibility would otherwise be prohibited under applicable law.

10-Day Right to Examine and Return this EOC

Please read this EOC. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This EOC will then be void from its start.

This EOC is signed for us as of the effective date as shown above.

UnitedHealthcare of Texas, Inc.

David Milich, President

What Is the Evidence of Coverage (EOC)?

This EOC is part of the Contract that is a legal document between UnitedHealthcare of Texas, Inc. and you and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this EOC. We issue this EOC based on the Subscriber's *Application* and payment of the required Premium.

In addition to this EOC, the Contract includes:

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

Can This EOC Change?

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

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Contract, as permitted by law.

The Contract will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this EOC.

We are delivering the Contract in *Texas*. The Contract is governed by *Texas* law.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the *Texas Department of Insurance* may be able to help.

Even if you file a complaint with the *Texas Department of Insurance*, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare of Texas, Inc.

To get information or file a complaint with your insurance company or HMO:

Call toll-free: Member Services at **1-866-811-2704**

Online: www.myuhc.com/exchange

Email: exchanges_go_complaints_intake@uhc.com

Mail: 1311 W. President George Bush Highway, Richardson, TX 75080

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el

Departamento de Seguros de Texas (*Texas Department of Insurance*, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el *Departamento de Seguros de Texas*, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare of Texas, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Servicios para Miembros al **1-866-811-2704**

En línea: www.myuhc.com/exchange

Correo electrónico: exchanges_go_complaints_intake@uhc.com

Dirección postal: 1311 W. President George Bush Highway, Richardson, TX 75080

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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TEXAS NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your EOC with UnitedHealthcare of Texas.

Please note that the Benefits specified below are subject to all terms, conditions, exclusions and limitations stated in your EOC and *Schedule of Benefits*, including, but not limited to, any applicable deductible amounts, Cost Share Percentage provisions, notification requirements, Co-payment amounts and dollar limits.

Examinations for Detection of Prostate Cancer

Benefits are provided for each male who is a Covered Person for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each male Covered Person who is:
  - at least 50 years of age; or
  - at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

Inpatient Stay following Birth of a Child

For each Covered Person for maternity/childbirth Benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery, and
- 96 hours following an uncomplicated delivery by cesarean section.

This Benefit does not require a covered female who is eligible for maternity/childbirth Benefits to (a) give birth in a Hospital or other health care facility or (b) remain in a Hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care Provider, and the mother will have the option of receiving the care at her home, the health care Provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any Covered Person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements

below the usual and customary rate; or (f) penalize a Physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The Benefits must be provided in a manner determined to be appropriate in consultation with the Covered Person and the attending Physician.

Any specific deductibles, Co-payments, and/or Cost Share Percentages applicable to the Benefits, which may not be greater than the deductibles, Co-payments and/or Cost Share Percentages applicable to other Benefits under this Plan are specified in your *Schedule of Benefits*.

Prohibitions: We may not (a) offer the Covered Person a financial incentive to forego breast reconstruction or waive the Benefits shown above; (b) condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the Benefits shown above; or (c) reduce or limit the amount paid to the Physician or Provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or Provider to provide care to a Covered Person in a manner inconsistent with the Benefits shown above.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the Covered Person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any Covered Person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Benefits are provided for each woman who is a Covered Person for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Benefits are for individuals age 18 or older, and include:

- A *CA 125* blood test; and
- A conventional *Pap smear* screening; or
    - A screening using liquid-based cytology methods, as approved by the *FDA*, alone or in combination with a test approved by the *FDA* for the detection of the *Human Papillomavirus*.
    - Coverage for any other test or screening approved by the *United States Food and Drug Administration* for the detection of ovarian cancer.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

Testing for the Detection of Colorectal Cancer

Testing for the detection of Colorectal Cancer Benefits are provided, for each Covered Person who is 45 years of age or older and at normal risk for developing colon cancer, for a medically recognized screening examination for the detection of colorectal cancer.

Covered expenses include:

- All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the *United States Preventive Services Task Force* for average-risk individuals, including the services that may be assigned a grade of “A” or “B” in the future; and
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal. If any person covered by this plan has questions concerning the above, please call UnitedHealthcare of Texas, Inc. at 1-866-811-2704, or write us at 1311 W. President George Bush Highway, Richardson, TX 75080. You may also visit www.myuhc.com/exchange or call the telephone number on your ID card.

How you're protected if your life or health insurance company fails

The *Texas Life and Health Insurance Guaranty Association* protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health Benefit plans, with some exceptions.
  - Up to $300,000 for disability income Benefits.
  - Up to $300,000 for long-term care insurance Benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death Benefits.
- **Individual annuities:** Up to $250,000 in the present value of Benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in *Chapter 463* of the *Texas Insurance Code*.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health Benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the *Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463)*. These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Introduction to Your Evidence of Coverage

This EOC and other Contract documents describe your Benefits, as well as your rights and responsibilities, under the Contract.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Texas, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

How Do You Use This Document?

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

Review the Benefit limitations of this EOC by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this EOC 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 EOC and any summaries provided to you, this EOC 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 ID card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Rights and Responsibilities

Texas Notice of Rights

UnitedHealthcare of Texas, Inc., a health maintenance organization (HMO), providing this plan covers no Benefits for services you receive from Out-of-Network Physicians or Providers, with specific exceptions as described in this EOC below, including any attachments.

You have the right to an adequate Network of in-Network Physicians and Providers (known as Network Physicians and Providers).

If you believe that the Network is inadequate, you may file a complaint with the *Texas Department of Insurance* at: www.tdi.texas.gov/consumer/complfrm.html.

If we approve a referral for Out-of-Network services because no Network Physician or Provider is available, or if you have received Out-of-Network Emergency Health Care Services, we must, in most cases, resolve the Out-of-Network Physician's or Provider's bill so that you only have to pay any applicable in-Network Co-payment, Cost Share Percentage, and deductible amounts.

You may obtain a current directory of Network Physicians and Providers at the following website: www.myuhc.com/exchange or by calling 1-866-811-2704 for assistance in finding available Network Physicians and Providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an Out-of-Network Physician or Provider paid as if it were from a Network Physician or Provider, if you present a copy of the inaccurate directory information to us, dated not more than 30 days before you received the service.

Enrollment and Required Premiums

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

- Your enrollment must be in accordance with the requirements of the Contract, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

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

The Contract 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.

If you have a chronic, disabling, or life threatening illness, you may apply to our medical director to use a non-Primary Care Physician Specialist as a Primary Care Physician (PCP).

Inpatient Care by Non-Primary Care Physician (PCP)

During an inpatient stay at a Network Hospital it may be appropriate for a Physician other than your Primary Care Physician (PCP) to direct and oversee your care, if your PCP does not do so. However, upon discharge, you must return to the care of your PCP or have your PCP coordinate care that may be Medically Necessary.

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 unless they qualify for an exemption from prior authorization requirements as defined in *TIC §4201.651-§4201.659*. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Your Physician or health care Provider may request a renewal of an existing prior authorization at least 60 days before the date the prior authorization expires. Further, if the request is received before the existing prior authorization expires, we, if practicable, will review and issue a determination before the existing prior authorization expires.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Cost Share Percentage 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 Cost Share Percentage 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 this EOC'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, as a result of an Emergency or if we refer you to an out-of-Network Provider, you or the out-of-Network Provider are responsible for requesting payment from us. The claim must be filed 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, Benefits payable under this plan for health care services for that condition or disability will be subject to the Coordination of Benefits (COB) provisions in this plan until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Contract for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage. If those services are also covered under another plan, then Benefits will be subject to the Coordination of Benefits provisions in the Contract.

Our Responsibilities

Determine Benefits

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 will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this EOC, 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 Contract, 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 Contract.

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 in accordance with one or more of the following methodologies:

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

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

amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You should contact us if you receive such a bill and we will work with the Provider so that you are only responsible for your Co-payment, Cost Share Percentage and/or deductible. 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/exchange or the telephone number on your ID card.

NOTICE: Although health care services may be or have been provided to you at a health care facility that is a member of the Provider Network used by your health benefit plan, other professional services may be or have been provided at or through the facility by Physicians and other healthcare practitioners who are not members of that Network. These Providers may balance bill you for any amounts not paid by your health benefit plan. If you receive a balance bill, you should contact us at www.myuhc.com/exchange or the telephone number on your ID card. You will only be responsible for any applicable Co-payment, Cost Share Percentage and/or any deductible for those professional services.

If specific Covered Health Care Services are not available from a Network Provider, you will be eligible for Medically Necessary Benefits when Covered Health Care Services are received from Out-of-Network Providers. In this situation, your Network Physician will submit a request for prior authorization of services to us. If care is not available from a Network Provider, your Network Physician may request for a review to be conducted by using a Specialist of the same or similar specialty as the Physician to whom the referral is requested prior to denial. Within the time appropriate to the circumstances relating to the delivery of the service and the condition of the patient, but not to exceed five business days after receipt of the requested documentation, we will work with you and your Network Physician to coordinate care through an Out-of-Network Provider. In this type of situation, Benefits for these Covered Health Care Services will be provided at the Network Benefit level and/or an agreed upon rate, and we hold the Covered Person harmless.

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/exchange for information regarding the vendor that provides the applicable methodology.

Notwithstanding the foregoing, in circumstances where you receive Emergency Health Care Services in an Out-of-Network facility, we will fully reimburse an Out-of-Network Physician or Provider for Emergency Health Care Services at the usual and customary rate or at an agreed rate until you can reasonably be expected to transfer to a Network Physician or Provider. If an Out-of-Network Provider for Emergency Health Care Services bills you for any difference between the Provider's billed charges and the Allowed Amount, you should contact us and we will work with the Provider so that you are only responsible for your cost share amount.

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.

Schedule of Benefits

UHC Gold Value+ ($5 Rx)

TX0015,None

How Do You Access Benefits?

Selecting a Network Primary Physician

You must select a Network Primary Care Physician, who is located in the Network Area, in order to obtain Benefits. 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 submit electronic referrals online to UnitedHealthcare for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the Network Area, for that child. If you do not select a Network Primary Care Physician for yourself or your Enrolled Dependent child, one will be assigned.

You may select any Network Primary Care Physician, who is located in the Network Area, accepting new patients. 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. For obstetrical or gynecological care, you do not need a referral from a Network Primary Care Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network Providers through www.myuhc.com/exchange or the telephone number on your ID card.

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/exchange . 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.

Covered Health Care Services must be provided by or referred by your Primary Care Physician. If care from another Network Physician is needed, your Primary Care Physician will submit an electronic referral online to UnitedHealthcare for services from that other Physician. The electronic referral must be received by UnitedHealthcare before the services are rendered. If you see a Network Physician without an electronic referral from your Primary Care Physician, you will be responsible for all charges and no Benefits will be paid, regardless of the place of service. This includes responsibility for charges for all related services and facility charges received from the Network Physician without the required referral. You should confirm what referrals have been submitted for you and the number of remaining visits on each referral by going to www.myuhc.com/exchange . You do not need a referral to see a Network obstetrician/gynecologist or to receive services through the Mental Health/Substance-Related and Addictive Disorders Designee.

Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from a UnitedHealthcare Individual Exchange Benefit Plan Network Provider. You can confirm that your Provider is a UnitedHealthcare Individual Exchange Benefit Plan Network Provider through the telephone number on your ID card or you can access a directory of Providers at www.myuhc.com/exchange . You should confirm that your Provider is a UnitedHealthcare Individual Exchange Benefit Plan Network Provider, including when receiving Covered Health Care Services for which you received a referral from your Primary Care Physician.

Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by Out-of-Network Providers. This Benefit plan does not provide an Out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided within the Network Area by a Network Physician or other Network Provider.

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.

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

You must show your identification card (ID card) every time you request health care services from a Network Provider. If you do not show your ID card, Network Providers have no way of knowing that you are enrolled under a UnitedHealthcare Contract. 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, this *Schedule of Benefits* will control.

Care Management

There may be additional services that are available to you, such as disease management programs, discharge planning, health education, and patient advocacy. When you seek prior authorization for a Covered Health Care Service as required or are otherwise identified as meeting eligibility requirements for a care management program, we will work with you to engage in the care management process and to provide you with information about these additional services.

Does Prior Authorization Apply

We require a request for prior authorization of services before you receive certain Covered Health Care Services. Your Primary Care Physician and other Network Providers are responsible for submitting a request for prior authorization of services to us before they provide these services to you.

Please note that requests for prior authorization are required even if you have an electronic referral submitted online to UnitedHealthcare by your Primary Care Physician to seek care from another Network Physician.

When a request for prior authorization is submitted, there are three possible responses that will be provided by us:

- A prior authorization.
- An Adverse Determination.
- Confirmation of receipt of your request when there are no clinical issues for us to determine.

Upon receiving the request for prior authorization and any additional information necessary to complete our review, we will communicate notice of our decision within three calendar days. If you are hospitalized at the time of the request for prior authorization, a determination will be provided within 24 hours. For services related to post-stabilization treatment or a life-threatening condition, a determination will not exceed one hour from receipt of the request.

If we issue an Adverse Determination, a written notice regarding the Adverse Determination will be forwarded to you and the Provider of record within three business days.

If you are hospitalized at the time of the Adverse Determination, we will provide notice within one business day by either telephone or electronic transmission to the Provider of record. Within three business days a written notice will be forwarded to you and the Provider of record.

A response will be provided no later than one hour after the time of request for post-stabilization care subsequent to Emergency treatment.

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.

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 calendar year basis.

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

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

NOTE: When Covered Health Care Services are provided by an Indian Health Service Provider, your cost share may be reduced.

Payment Term and Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Contract as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drug section*, the *Pediatric Vision Care Services section* and the *Pediatric Dental Care Services section.* Benefits for outpatient prescription drugs on the PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible. 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. 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 *Schedule of Benefits* table.	No Annual Deductible.

<table>
<tr><th>Payment Term and Description</th><th>Amounts</th></tr>
<tr><td>Out-of-Pocket Limit</td><td></td></tr>
<tr><td>The maximum you pay per year for the Annual Deductible, Co-payments or Cost Share Percentage. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Contract as indicated in this Schedule of Benefits including Covered Health Care Services provided under the Outpatient Prescription Drug section, the Pediatric Vision Care Services section and the Pediatric Dental Care Services section.

Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.

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:
• Any charges for non-Covered Health Care Services.
• Charges that exceed Allowed Amounts, when applicable.</td><td>$8,700 per Covered Person, not to exceed $17,400 for all Covered Persons in a family.

The Out-of-Pocket Limit includes the Annual Deductible.</td></tr>
<tr><td colspan="2">Co-payment</td></tr>
<tr><td colspan="2">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.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of:
• The applicable Co-payment.
• The Allowed Amount or the Recognized Amount when applicable.

Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.

UnitedHealthcare will not establish a Co-payment that exceeds 50 percent of the total cost of services provided.</td></tr>
<tr><td colspan="2">Cost Share Percentage</td></tr>
<tr><td colspan="2">Cost Share Percentage 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.

Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.</td></tr>
</table>

Schedule of Benefits Table

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Emergency Ambulance Services Allowed Amounts for Air Ambulance transport provided by an Out-of-Network Provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance:* 50%	Yes	No
	Air Ambulance: 50%	Yes	No
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate.	*Ground Ambulance:* 50%	Yes	No
Allowed Amounts for Air Ambulance transport provided by an Out-of-Network Provider will be determined as described below under Allowed Amounts in this *Schedule of Benefits.*	*Air Ambulance:* 50%	Yes	No
2. Clinical Trials			
	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*.		
3. Dental Services - Accident Only			
	50%	Yes	No
4. Diabetes Services			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Diabetes Self-Management and Educational Services	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 *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME)*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME)* and in the *Outpatient Prescription Drug section.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug section.*		
5. Durable Medical Equipment (DME)			
Benefits are limited to a single purchase of a type of DME every three years. Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. You must purchase or rent the DME from a Network vendor or purchase it directly from the prescribing Network Physician.	50%	Yes	No
6. Emergency Health Care Services - Outpatient			
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	20%	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER Services, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Cost Share Percentage and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an Out-of-Network Provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.* ***Non-Emergent ER Services -*** Limited to $200 per visit for Non-Emergent ER Services.			
7. Enteral Nutrition			
	50%	Yes	No
8. Family Planning Services			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	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.		
	50%	Yes	No
9. Habilitative Services			
	Inpatient 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.*		
	Outpatient 20%	Yes	No
10. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every 36 months for Covered Persons age 18 and under. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	50%	Yes	No
11. Home Health Care			
	50%	Yes	No
12. Hospice Care			
	50%	Yes	No
13. Hospital - Inpatient Stay			
	20%	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
14. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:	$30 per service at a freestanding lab or in a Physician's office	Yes	No
	$65 per service at a Hospital-based lab	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient:	20% at a freestanding diagnostic center or in a Physician's office	Yes	No
	40% at an outpatient Hospital-based diagnostic center	Yes	No
15. Major Diagnostic and Imaging - Outpatient			
	20% at a freestanding diagnostic center or in a Physician's office	Yes	No
	40% at an outpatient Hospital-based diagnostic center	Yes	No
16. Manipulative Treatments			
	20%	Yes	No
17. Mental Health Care and Substance-Related and Addictive Disorders Services			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Inpatient 20%	Yes	No
	Outpatient 20%per session for Partial Hospitalization/Intensive Outpatient Treatment *Office Visit* $70 per visit	Yes Yes	No No
18. Necessary Medical Supplies			
	50%	Yes	No
19. Orthotics			
	50%	Yes	No
20. Pharmaceutical Products - Outpatient			
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. **Note**: Benefits for medication normally available by a prescription or order or refill are provided as described under the *Outpatient Prescription Drug* section.	50%	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
21. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an Out-of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	20% for services at an ambulatory surgical center or in a Physician's office	Yes	No
	40% for services at an outpatient Hospital-based surgical center	Yes	No
22. Physician's Office Services - Sickness and Injury			
	$30per visit for a Primary Care Physician Telehealth/Telemedicine visit	Yes	No
	$30per visit for services provided by your Primary Care Physician	Yes	No
	$70 per visit for services provided by a Network Specialist or other Network Physician	Yes	No
23. Pregnancy - Maternity Services			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Breast pumps	None	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
24. Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
25. Prosthetic Devices			
Benefits are available for items required by the *Women's Health and Cancer Rights Act of 1998*.	50%	Yes	No
26. Reconstructive Procedures			
	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*.		
27. Rehabilitation Services - Outpatient Therapy			
	Outpatient 20%	Yes	No
Acquired Brain Injury (ABI) benefit	Depending upon where the covered expense is provided, the cost share will be the same as the deductible amount, Cost Share Percentage, and/or Co-payment amount as stated in the Data Page under *Emergency*, *Hospital Inpatient Stay*, *Lab, X-Ray and Diagnostics - Outpatient,* Mental Disorders and Substance Abuse, *Physician Fees* and Office Visits for Injury or Illness, Prescription Drugs – Outpatient and *Urgent Care Services*.		
28. Scopic Procedures - Outpatient Diagnostic and Therapeutic			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	No
29. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
	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*.		
	20%	Yes	No
30. Surgery - Outpatient			
Benefits for bone-anchored hearing aids are available to Covered Persons age 18 and under, and are limited to one hearing instrument per hearing impaired ear every 36 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.	20% for services at an ambulatory surgical center or in a Physician's office	Yes	No
	40% for services at an outpatient Hospital-based surgical center	Yes	No
31. Telehealth			
Benefits include Telehealth Services, Telemedicine Medical Services, and Tele dentistry Dental Services but do not include virtual care services provided by a Designated Virtual Network Provider.	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*.		
32. Temporomandibular Joint Syndrome (TMJ)			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	No
33. Therapeutic Treatments - Outpatient			
	20%	Yes	No
34. Transplantation Services			
Transplantation services must be received from a Designated Provider. Covered expenses for lodging and ground transportation limited to $10,000.	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.*		
35. Urgent Care Center Services			
Co-payment/Cost Share Percentage 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 under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.*	$60 per visit	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under the Contract.			
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 your EOC, 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 Cost Share Percentage You Pay? This May Include a Co-payment, Cost Share Percentage or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			
36. Virtual Care Services			
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/exchange or the telephone number on your ID card.	*Primary Care* $30 per visit	Yes	No
	Urgent Care $30 per visit	Yes	No

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 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, Cost Share Percentage or deductible which is based on the Recognized Amount as defined in your EOC.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria as described below****, you* are not responsible, and the Out-of-Network Provider may not bill you, for amounts in excess of your Co-payment, Cost Share Percentage or deductible which is based on the Recognized Amount as defined in your EOC*.*
- 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, Cost Share Percentage or deductible which is based on the Recognized Amount as defined in your EOC*.*
- 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, Cost Share Percentage or deductible which is based on the rates that would apply if the service was provided by a Network Provider.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in your EOC.

For 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, 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 Cost Share Percentage, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an Out-of-Network Provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from Out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Ac*t with respect to a visit as defined by the Secretary, the Allowed Amount is based on either:

- The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement.*
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary*.*

IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and an Out-of-Network Physician may not bill you, for amounts in

excess of your applicable Co-payment, Cost Share Percentage or deductible which is based on the Recognized Amount as defined in your EOC.

For Emergency Health Care Services provided by an Out-of-Network Provider, the Allowed Amount is based on either:

- The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement.*
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network Provider may not bill you, for amounts in excess of your applicable Co-payment, Cost Share Percentage or deductible which is based on the Recognized Amount as defined in your EOC.

For Air Ambulance transportation provided by an Out-of-Network Provider, the Allowed Amount is based on either:

- The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network Provider may not bill you, for amounts in excess of your Co-payment, Cost Share Percentage or deductible which is based on the rates that would apply if the service was provided by a Network Provider.

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/exchange 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 prior to receipt of the Covered Health Care Service that the Provider was a Network Provider, either through a database, Provider directory, or in a 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, Cost Share Percentage 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 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 will assist you with selecting a high-quality Designated Provider. 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.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider.

You or your Network Physician must notify us of special service needs (such as transplants or bariatric surgery) 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, Benefits will not be paid unless your care is the result of an Emergency or we refer you to an Out-of-Network Provider.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network Provider, you may be eligible for 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.

Schedule of Benefits: Outpatient Prescription Drugs

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Cost Share Percentage or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

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 Cost Share Percentage may change or you will no longer have Benefits for that particular Brand-name Prescription Drug 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 Cost Share Percentage, 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/exchange or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, 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.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you will be responsible for paying all charges and no Benefits will be paid. 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/exchange 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. You may seek reimbursement from us as described in your EOC 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, less the required Co-payment and/or Cost Share Percentage 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/exchange or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

In the case of *FDA-approved* drugs for the treatment of stage-four advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

When a step therapy requirement applies to a Prescription Drug Product, your Provider may request an exception. See *Step Therapy Exception Requests* in *Section 10: Outpatient Prescription Drugs* of the Contract for details. If your step therapy exception request is denied, please refer to *Section 6: Questions, Complaints and Appeals* of your Contract for additional information on appealing an Adverse Determination.

What Do You Pay?

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your EOC before Benefits for Prescription Drug Products under this section are available to you unless otherwise allowed under this section. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

You are responsible for paying the applicable Co-payment and/or Cost Share Percentage described in the Benefit Information table. You are not responsible for paying a Co-payment and/or Cost Share Percentage for PPACA Zero Cost Share Preventive Care Medications.

The Co-payment amount or Cost Share Percentage you pay for a Prescription Drug Product will not exceed the Usual and Customary Charge of the Prescription Drug Product.

The amount you pay for any of the following under this section may not be included in calculating any Out-of-Pocket Limit stated in your EOC:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- 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

NOTE: When Covered Health Care Services are provided by an Indian Health Service Provider, your cost share may be reduced.

Payment Term And Description	Amounts
Co-payment and/or Cost Share Percentage	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Cost Share Percentage*** Cost Share Percentage for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Co-payment and Cost Share Percentage*** Your Co-payment and/or Cost Share Percentage is determined by the IEPMC's tier placement of a Prescription Drug Product. Your Co-payment and/or Cost Share Percentage 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/exchange or the telephone number on your ID card. **Special Programs**: We may have certain programs in which you may receive a reduced or increased Co-payment and/or Cost Share Percentage 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/exchange or the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy or Preferred Retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Cost Share Percentage. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Cost Share Percentage. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Cost Share Percentage stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Cost Share Percentage for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Co-payment/Cost Share Percentage 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 Cost Share Percentage for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist**: You may receive a reduced or increased Co-payment and/or Cost Share Percentage 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 Cost Share Percentage by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. **NOTE**: The tier status of a Prescription Drug Product can change from time to time. These changes may happen up to monthly, based on the IEPMC 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/exchange or the telephone number on your ID card for the most up-to-date tier status.	

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.	
Description and Supply Limits	**What Is the Co-payment or Cost Share Percentage You Pay?** **This May Include a Co-payment, Cost Share Percentage or Both**
Specialty Prescription Drug Products	
The following supply limits apply.	Your Co-payment and/or Cost Share Percentage is determined by the IEPMC's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug

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.	
Description and Supply Limits	**What Is the Co-payment or Cost Share Percentage You Pay?** **This May Include a Co-payment, Cost Share Percentage or Both**
• As written by the Provider, up to a consecutive 30-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 Split Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Co-payment and/or Cost Share Percentage that applies will reflect the number of days dispensed or days the drug will be delivered. Supply limits apply to any Network Pharmacy.	Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For up to a 30-day supply at a Network Pharmacy, you pay: For a Tier 1 Specialty Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 4 Specialty Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 5 Specialty Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5 of the Prescription Drug List are not covered.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the Provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Co-payment and/or Cost Share Percentage that applies will reflect the	Your Co-payment and/or Cost Share Percentage is determined by the IEPMC'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, Tier 4, or Tier 5. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible.

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.	
Description and Supply Limits	**What Is the Co-payment or Cost Share Percentage You Pay?** **This May Include a Co-payment, Cost Share Percentage or Both**
number of days dispensed or days the drug will be delivered. • Your Co-payment or Cost Share Percentage for insulin will not exceed the amount allowed by applicable law.	For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 5 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5 of the Prescription Drug List are not covered.
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply: • As written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Cost Share Percentage based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill	Your Co-payment and/or Cost Share Percentage is determined by the IEPMC's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out tier status. For up to a 90-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product:$10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $80 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 5 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. No Co-payment Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5 of the Prescription Drug List are not covered.

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.	
Description and Supply Limits	**What Is the Co-payment or Cost Share Percentage You Pay?** **This May Include a Co-payment, Cost Share Percentage or Both**
for a 90-day supply, not a 30-day supply with three refills.	
Preferred Retail Network Pharmacy	
The following supply limits apply: • As written by the Provider, up to a consecutive 30-day or 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • Your Co-payment or Cost Share Percentage for insulin will not exceed the amount allowed by applicable law.	Your Co-payment and/or Cost Share Percentage is determined by the IEPMC's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out tier status. For up to a 30-day supply at a Preferred Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 5 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. No Co-payment For up to a 90-day supply at a Preferred Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $80 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $80 of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible.

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.	
Description and Supply Limits	**What Is the Co-payment or Cost Share Percentage You Pay?** **This May Include a Co-payment, Cost Share Percentage or Both**
	For a Tier 5 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5 of the Prescription Drug List are not covered.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 8: Defined Terms*.)
- You receive Covered Health Care Services while the Contract 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.

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 Contract.

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 Cost Share Percentage).
- 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.
- Co-payments will not exceed 50% of the total cost of services provided. Plus, the total Co-payments will not exceed 200% of the annual Premium paid on your behalf (or, if you have family coverage, paid on behalf of all Covered Persons in your family.) This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

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. Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

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

3. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Contract, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 24 months of the accident, or if not a Covered Person at the time of the accident, within the first 24 months of coverage under the Contract.

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.

4. Diabetes Services

Diabetes Self-Management and Training and Education Services

"Diabetes self-management training and educational services" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications, when the instruction is provided in accordance with a program in compliance with the *National Standards of Diabetes Self-Management Education Program* as developed by the *American Diabetes Association*. Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a health care professional and when provided by a certified, registered or licensed health care professional. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction.

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

Diabetic Self-Management Items

Benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and tablets, and single measurement glucose monitors, excluding continuous glucose monitors, are described under the *Outpatient Prescription Drug Benefit*. An insulin pump and continuous glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME)*.

5. Durable Medical Equipment (DME)

Benefits are provided for DME. 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 includes, but isn't limited to:

- Continuous glucose monitors.
- Canes.
- Commode chairs.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Walkers.
- Manual wheelchairs.

Benefits for cochlear implants are limited to one in each ear with internal replacement as medically or audiologically necessary. Benefits also include external cochlear devices and systems, including external speech processor and controller with necessary components. 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.*

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 EOC.

6. 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, Alternate Facility, Freestanding Emergency Medical Care Facility or a comparable emergency 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). Benefits for Non-Emergent ER Services are limited as described in the *Schedule of Benefits*.

When Emergency Health Care Services are received in a Physician's office, the Benefits will be paid as described in *Physician's Office Services - Sickness and Injury below*.

When Emergency Health Care Services are received on an inpatient basis, Benefits will be paid as described in *Hospital - Inpatient Stay* below.

The Network deductible may apply to out-of-Network Emergency Health Care Services in the same manner as Network Emergency Health Care Services. A separate out-of-Network deductible will not be applied to Emergency Health Care Services.

7. 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 affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndrome.
- Eosinophilic disorders, as evidenced by the results of a biopsy.

Benefits for prescription or over-the-counter formula 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.

8. Family Planning Services

Covered expenses include charges incurred by a Covered Person for:

A. Sterilization, including female tubal ligation and male vasectomy.

B. Contraceptive devices, including the insertion or removal of, and any Medically Necessary consultations, examinations, or procedures associated with, the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives.

9. 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.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.
- Dietary or nutritional evaluations for developmental delay provided in accordance with an individualized family service plan issued by the *Interagency Council on Early Childhood Intervention.*

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

10. Hearing Aids

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

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

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

Cochlear implants are not 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 EOC. 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.

11. 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 vocational practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health 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.

12. Hospice Care

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

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

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

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

13. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Meals and special diets when Medically Necessary.
- Inpatient care for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer. The Covered Person and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- General nursing care.
- Private duty nursing when Medically Necessary.
- Use of operating room and related facilities.
- Use of intensive care unit and services.
- X-ray services.
- Laboratory and other diagnostic tests.
- Drugs, medications, biologicals, anesthesia and oxygen services.
- Radiation therapy.
- Inhalation therapy.
- Whole blood including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the Covered Person.
- Administration of whole blood and blood plasma.
- Short term rehabilitation services in the acute Hospital setting.

14. Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

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

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*.

15. 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*.)
- Diagnostic Imaging.

16. Manipulative Treatments

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services.

Benefits are limited as described in the *Schedule of Benefits*.

17. 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 properly qualified behavioral health Provider.

Benefits include the following levels of care:

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

- Outpatient treatment.

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

Services include the following:

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

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

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 referrals to Providers and coordination of care.

18. Necessary Medical Supplies

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

19. Orthotics

Orthotic devices means rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

Orthotic braces, including needed changes to shoes to fit braces, braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service. Professional services related to the fitting and use of orthotic devices are Covered Health Care Services.

Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations*.

20. 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 EOC. Benefits for medication normally available by a prescription or order or refill are provided as described under *Section 10: Outpatient Prescription Drugs.*

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. In the case of *FDA-approved* drugs for the treatment of stage-four advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com/exchange 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/exchange or the telephone number on your ID card.

21. 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.

22. Physician's Office Services - Sickness and Injury

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

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

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional. Examples of this covered benefit include dietary or nutritional evaluations for children with developmental delays.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Benefits also include necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.

Covered Health Care Services also include Remote Physiologic Monitoring Services.

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.*

23. 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 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/exchange 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.

If the discharge occurs earlier or if the delivery does not occur in a Hospital or other facility, Benefits are included for post-delivery care when provided by a Physician, a registered nurse or other appropriately licensed Provider, either in the mother's home or at another location determined to be appropriate.

Post-delivery care includes services provided in accordance with accepted maternal and neonatal physical assessment, parent education, breast or bottle feeding, educational/training and performance of necessary and appropriate clinical tests.

24. 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,* including contraceptive services and supplies. Women may select an obstetrician or gynecologist in addition to a Primary Care Physician or access obstetrics and gynecology services directly from an obstetrician or gynecologist. You may receive these services without prior authorization or a referral from your Primary Care Physician.
- 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.*

- As required under *Texas HMO* law, preventive care includes the following:
  - Periodic health exams for adults.
  - Immunizations for children.
  - Well-child care from birth.
  - Eye and ear exams for children to determine the need for vision and hearing correction in accordance with established medical guidelines.
  - Immunizations for adults in accordance with the *United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions*, or its successor.
  - Preventive screening to evaluate abnormalities related to dense breast tissue.
  - Coverage of Tests for Detection of *Human Papillomavirus*, Ovarian Cancer, and Cervical Cancer

    Benefits are provided for each woman who is a Covered Person for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Benefits are for individuals age 18 or older, and include:

    - A *CA 125* blood test; and
    - A conventional *Pap smear* screening; or
      - A screening using liquid-based cytology methods, as approved by the *FDA*, alone or in combination with a test approved by the *FDA* for the detection of the *Human Papillomavirus*.
    - Coverage for any other test or screening approved by the *United States Food and Drug Administration* for the detection of ovarian cancer.

25. 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 and wigs as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras.

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 EOC.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic device that meets the minimum specifications for your needs, as determined by your treating Physician or prosthetist. 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. Professional services related to the fitting and use of prosthetic devices are Covered Health Care Services.

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

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

26. Reconstructive Procedures

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

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

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

Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child. 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.

Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of, or attempt to create the normal appearance of, an abnormal structure caused by congenital defects, development of deformities, trauma, tumor, infections, or disease.

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 physical complications, including lymphedemas, at all stages of mastectomy, 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.

27. 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.
- Dietary or nutritional evaluations for developmental delay provided in accordance with an individualized family service plan issued by the *Interagency Council on Early Childhood Intervention*.

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.

Benefits are available only for rehabilitation services that are expected to restore a Covered Person to the previous level of functioning. Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Covered Person previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Acquired Brain Injury Benefits

Benefits are provided for Covered Health Care Services that are determined by a Physician to be Medically Necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain, which is not hereditary, congenital or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Benefits are provided for the Covered Health Care Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury, and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

- **Cognitive communication therapy.** Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- **Cognitive rehabilitation therapy.** Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- **Community reintegration services.** Services that facilitate the continuum of care as an affected individual transitions into the community.
- **Neurobehavioral testing.** An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- **Neurobehavioral treatment.** Interventions that focus on behavior and the variables that control behavior.
- **Neurocognitive rehabilitation.** Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- **Neurocognitive therapy.** Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- **Neurofeedback therapy.** Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- **Neurophysiological testing.** An evaluation of the functions of the nervous system.
- **Neurophysiological treatment.** Interventions that focus on the functions of the nervous system.
- **Neuropsychological testing.** The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

- **Neuropsychological treatment.** Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
    - **Outpatient day treatment services** - Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-Residential Treatment settings.
    - **Post-acute care treatment services** - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
        - Post-acute care services necessary as a result of and related to an acquired brain injury are limited to the following: post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date.
        - Reasonable costs may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.
- **Post-acute transition services.** Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- **Psychophysiological testing.** An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- **Psychophysiological treatment.** Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- **Remediation.** The process of restoring or improving a specific function.
- **Treatment facilities.** Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation Hospital and Assisted Living Facility.
    - Although Benefits may be available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined under *Types of Care* in *Section 2: Exclusions and Limitations* in this EOC, regardless of where the services are provided.

28. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

29. 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.

Benefits are not available for services in a Long-term Acute Care Facility (LTAC).

30. Surgery - Outpatient

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

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

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

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*.)

Tissue transplants and cornea transplants when ordered by a Physician. Benefits are available for tissue and cornea transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

31. Telehealth

Benefits include Telehealth Services, Telemedicine Medical Services, and Teledentistry Dental Services. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section. An in-person consultation is not required between the health care provider and the patient for services to be provided.

Telehealth Services, Telemedicine Medical Services, and Teledentistry Dental Services do not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services*.

32. Temporomandibular Joint Syndrome (TMJ)

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders when treatment is needed for:

- Accidental damage.
- Trauma.
- Congenital Anomaly.
- Developmental defect.
- Pathology.

Benefits include services for diagnostic and surgical treatment that is recognized by us as a generally accepted form of care or treatment, according to prevailing standards of the medical and dental practice profession as effective and appropriate for the diagnosis and surgical treatment of temporomandibular joint and craniomandibular disorders.

Benefits for non-surgical treatment of temporomandibular joint and craniomandibular disorders include intra-oral splints that stabilize or reposition the jaw joint.

Benefits do not include charges that are incurred for any service related to fixed or removable appliances that involve movement or repositioning of the teeth, occlusal (bite) adjustments, treatment of malocclusion, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures, dental implants).

33. Therapeutic Treatments - Outpatient

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

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

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

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

Benefits include:

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

34. Transplantation Services

Organ transplants 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.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Contract, 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.

35. 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*.

36. 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).

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/exchange or the telephone number on your ID card.

Benefits are available for the following:

- Primary care, which is general and non-Emergency care, delivered through live audio with video-conferencing or audio only technology from a Primary Care Physician. Benefits for virtual primary care are available only to Covered Persons age 18 or over.

- Urgent on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-Emergency medical needs.

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

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

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.

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 Contract.

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

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

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

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 Contract, 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 accident-related dental services for which benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services* or 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.

3. Dental implants, bone grafts and other implant-related procedures.
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 braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, and Supplies* in *Section 1: Covered Health Care Services.*
3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery and/or facilitate a successful surgical outcome.
4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Devices and computers to help in communication and speech.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.

9. Powered and non-powered exoskeleton devices.

10. Powered Wheelchairs

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. See *Section 10: Outpatient Prescription Drugs* for prescription drug products covered under the pharmacy Benefit.

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.

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. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.* This exclusion does not apply to PPACA Zero Cost Share Preventive Care Medications for which Benefits are provided under the *Pharmacy Benefit* as described in *Section 10: Outpatient Prescription Drugs.*

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 of 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 monthly.

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 monthly.

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 monthly.

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 monthly.

11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

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

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

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
8. Shoe inserts.
9. Arch supports.

G. Gender Dysphoria

1. Transgender surgery, including medical or psychological counseling and hormonal therapy in preparation for and subsequent to any such surgery is excluded.
2. 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.
- 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.
   - Items routinely found in the home.
   - Ostomy Supplies.
   - Urinary catheters.

   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) and Prosthetic Devices* in *Section 1: Covered Health Care Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Tubings except when used with DME as described under *Durable Medical Equipment (DME)* 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, conduct and disruptive impulse control and conduct disorders, 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 Transitional Living, Sober Living and Halfway House 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.
10. Services provided in unlicensed, and, or non-accredited program. Treatment or services that are non-professionally directed.
11. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

J. Nutrition

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

    This exclusion does not apply to:

- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Care Services*, which meet the definition of a Covered Health Care Service.
- Enteral formulas and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as listed in the Benefit plan.

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 8: Defined Terms*. Examples include:
   - Membership costs and fees for health clubs and gyms.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the 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, except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Prosthetic Devices* in *Section 1: Covered Health Care Services*.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services 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 impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.

6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.

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. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.

9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.

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.

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.

13. Breast reduction and augmentation 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.*

14. Helicobacter pylori *(H. pylori)* serologic testing.

15. Intracellular micronutrient testing.

N. Providers

1. Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.

2. Services performed by a Provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other Provider. Services which are self-directed to a Freestanding Facility or a 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.

   The following infertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor 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).
   - 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.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat erectile dysfunction and/or impotency.
8. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). This exclusion does not apply to therapeutic abortion recommended by a doctor and performed to save the life of the mother.
9. Fetal reduction surgery.

P. Services Provided under another Plan

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

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

4. Health care services during active military duty.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* and/or *Surgery – Outpatient 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 Contract.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider.

R. Travel

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

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing, except as described in *Section 1: Covered Health Care Services*.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* and *Acquired Brain Injury* 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).
9. Benefits are not available for services in a Long-term Acute Care Facility (LTAC).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

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 EOC under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this EOC 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 Contract 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 Contract 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 Contract ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Contract.
6. In the event an Out-of-Network Provider waives, does not pursue, or fails to collect, Co-payments, Cost Share Percentage 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, Cost Share Percentage 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 storage:
   - Long term storage services are not a Covered Health Care Service.
   - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a Covered Person is entering the military, etc., we will not cover any long-term storage of the above.
   - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
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. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).

13. Blood or tissue typing for paternity testing are not a covered service.

14. Specimen Provenance testing are not a covered service.

15. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the Benefit plan.

16. Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.

17. Stand-by availability of a medical practitioner when no treatment is rendered.

18. Services or supplies that are provided prior to the effective date or after the termination date of the Contract.

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the federal Health Insurance Marketplace®, available at HealthCare.gov. 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 Contract.

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. Network Benefits are available only if you receive Covered Health Care Services from Network Providers.

Who Is Eligible for Coverage?

The federal Health Insurance Marketplace determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the federal Health Insurance Marketplace. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the federal Health Insurance Marketplace.

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 8: Defined Terms*.

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

When Do You Enroll and When Does Coverage Begin?

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

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the federal Health Insurance Marketplace.

Coverage begins on the date determined by the federal Health Insurance Marketplace and identified in the Contract if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the federal Health Insurance Marketplace.

Adding New Dependents

Subscribers may enroll Dependents only as determined by the federal Health Insurance Marketplace.

The Subscriber must notify the federal Health Insurance Marketplace of a new Dependent to be added to the Contract. The effective date of the Dependent's coverage must follow the federal Health Insurance Marketplace rules. Additional Premium may also be required, and it will be calculated from the date determined by the federal Health Insurance Marketplace.

NOTE: Subject to a determination of the federal Health Insurance Marketplace, an eligible child born to you or your spouse will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for loss due to Injury and Sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Premiums

All Premiums are payable on a monthly basis, by the Subscriber. The first Premium is due and payable on the effective date of the Contract. Subsequent Premiums are due and payable no later than the first day of the month thereafter that the Contract is in effect.

We will also accept Premium payments from the following third parties:

- *Ryan White HIV/AIDS Program* under title XXVI of the *Public Health Service Act.*
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care Provider or any health care Provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which your coverage becomes effective.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Misstatement of Age or Tobacco Use

If your age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the federal Health Insurance Marketplace of your new residence. Your Premium will be based on your new residence beginning on the date determined by the federal Health Insurance Marketplace. If the change in residence results in the Subscriber no longer living in the Service Area, the Contract will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under the Contract shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Subscriber shall be held liable for the cost of

services received during the grace period. In no event shall the grace period extend beyond the date the Contract terminates.

We may pay Benefits for Covered Health Care Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under *section 36B of title 26*, as provided for by the *Patient Protection and Affordable Care Act (PPACA),* you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Care Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Subscriber at least 60 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

We will refund any Premium paid and not earned due to Contract termination.

The Contract may also terminate due to changes in the actuarial value requirements under state or federal law. If the Contract terminates for this reason, a new Contract, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under the Contract or under any subsequent coverage you have with us.

The Contract will renew on January 1 of each calendar year. However, we may refuse renewal if any of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Contract Ends* below.
- There is fraud or intentional misrepresentation made by you or with your knowledge in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.
- Your eligibility would otherwise be prohibited under applicable law.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Contract Ends**

  Your coverage ends on the date the Contract ends. That date will be one of the following:

  - The date determined by the federal Health Insurance Marketplace that the Contract will terminate because the Subscriber no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate the Contract because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of Benefits, for all residents of the state where you reside.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate the Contract because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Subscriber or an Enrolled Dependent, as determined by the federal Health Insurance Marketplace. Please refer to *Section 8: Defined Terms* for definitions of the terms “Eligible Person,” “Subscriber,” "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the date determined by the federal Health Insurance Marketplace rules if we receive notice from the federal Health Insurance Marketplace instructing us to end your coverage.

  Your coverage ends on the date determined by the federal Health Insurance Marketplace rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **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 Contract.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care Provider or any health care Provider sponsored organization for any portion of the Premium for coverage under the Contract. This prohibition does not apply to the following third parties:

  - *Ryan White HIV/AIDS Program* under *title XXVI of the Public Health Service Act.*
  - Indian tribes, tribal organizations or urban Indian organizations
  - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Reinstatement

When coverage under the Contract terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Contract, subject to the rules of the federal Health Insurance Marketplace.

Continuance of Coverage Due to Change in Marital Status

If a Covered Person loses coverage due to a change in marital status, you may be issued coverage that most nearly approximates the coverage of the Contract that was in effect prior to the change in marital status. In order to convert, you must continue to reside in the Service Area, submit an application within thirty-one days after the date of the change in marital status, and submit Premium payments required under such Contract. Subject to a determination by the federal Health Insurance Marketplace, the effective date of such coverage shall be the effective date of coverage under the prior Contract.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network Providers directly for your Covered Health Care Services. If a Network Provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Cost Share Percentages to a Network Provider.

Receipt of Notice of Claim

After we receive notice of a claim, we will do the following within 15 days:

- Acknowledge receipt of the claim.
- Commence any investigation of the claim.
- Request all items, statements and forms that we reasonably believe will be required from the claimant.

We may make additional requests for information if additional requests are necessary during the investigation.

Notice of Acceptance or Rejection of Claim

We will notify you in writing of our acceptance or rejection of a claim within 15 business days after we receive all items, statements and forms we require to secure final proof of loss unless:

- We have a reasonable basis to believe that the loss resulted from arson. If this is the case, we will notify the claimant in writing of our acceptance or rejection of the claim not later than 30 days after the date we receive all items, statements and forms required by the insurer.
- We are unable to accept or reject the claim within the periods above. In this situation, we must notify the claimant, within that same period that we need additional time. We must accept or reject the claim within 45 days after the date we notify the claimant that additional time is needed.

If we reject the claim, the notice of rejection will state the reasons for the rejection.

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 as a result of an Emergency or if we refer you to an out-of-Network Provider, you or the out-of-Network Provider are responsible for requesting payment from us. The claim must be filed in a format that contains all of the information we require, as described below.

Notice of Claim

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.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under Required Information.

Required Information

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

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

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

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

OptumRx Claims Department,

PO Box 650540,

Dallas, TX 75265-0540

Payment of Claims

We will pay a claim by the fifth business day after notice is sent. If payment of a claim or part of a claim is conditioned on the performance of an act by the claimant, we will pay the claim by the fifth business day after the act is performed.

You may not assign your Benefits under the Contract to an Out-of-Network Provider, of Emergency Health Care Services or services arranged by us, without our consent. When an assignment is not obtained, we will send the reimbursement directly to you for you to reimburse them upon receipt of their bill. We may, however, pay an Out-of-Network Provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an Out-of-Network Provider, of Emergency Health Care Services or services arranged by us, we reserve the right to offset Benefits to be paid to the Provider by any amounts that the Provider owes us.

In circumstances where you receive Emergency Heath Care Services in an Out-of-Network facility, we will fully reimburse an Out-of-Network Physician or Provider (within the assignment parameters described above) for Emergency Heath Care Services at the usual and customary rate or at an agreed rate until you can reasonably be expected to transfer to a Network Physician or Provider. If an Out-of-Network Provider for Emergency Heath Care Services bills you for any difference between the Provider's billed charges and the Allowed Amount, you should contact us and we will work with the Provider so that you are only responsible for your cost share amount.

When you assign your Benefits under the Contract to an Out-of-Network Provider, of Emergency Health Care Services or services arranged by us and the Out-of-Network Provider submits a claim for payment, you and the Out-of-Network Provider represent the following:

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

Payment of Benefits under the Contract shall be in cash or cash equivalents, or in a form of other consideration determined 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 the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will send you a one-page complaint form that you must return to us for prompt resolution of the complaint.

If you would rather send your complaint to us in writing, our address is:

UnitedHealthcare Appeals & Grievances
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630

We will promptly investigate each complaint. Within five business days, we will send a letter acknowledging the date we received your complaint. The total time for acknowledgement, investigation and resolution of the complaint, including the response letter, will not exceed 30 calendar days after we receive the written complaint or one-page complaint form.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case, and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Covered Person, Physician or Provider. We will not retaliate for any reason including, cancellation of coverage or a Provider contract, or refusal to renew coverage or a Provider contract because the Covered Person, Physician, Provider or person acting on behalf of the Covered Person has filed a complaint against the Plan or has appealed a decision.

Complaint Appeal Procedures

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision.

We will send an acknowledgment letter to the complainant within five business days after the date we receive the written request for an appeal.

We will appoint members to the complaint appeal panel, which advises us on the resolution of the appeal. The members of the complaint appeal panel cannot have been involved with your complaint in the past. The complaint appeal panel will include an equal number of our staff, Physicians or other Providers with experience in the area of care to which your appeal relates, and Covered Persons.

No later than the fifth business day before the complaint appeal panel meets, we will provide to you or your designated representative with the following:

- Any documentation that will be presented by our staff to the complaint appeal panel.
- The specialization of any Physician or Provider consulted during the investigation of your appeal.
- The name and affiliation of each of the members of our complaint appeal panel.

You, or your designated representative if you are a minor or disabled, have the right to:

- Appear in person before the complaint appeal panel at the site at which the Covered Person normally receives health care services, or at another site agreed to by the complainant.
- Address an appeal over the phone or in writing to the complaint appeal panel.
- Present alternative expert testimony.
- Request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your written appeal. Our final decision on the appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Investigation and resolution of appeals involving ongoing Emergencies or denials of continued hospitalization will be resolved in accordance with the medical immediacy of the case but no later than one business day after your request for appeal. At your request, we will provide, instead of a complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the medical condition, procedure, or treatment under appeal. The Physician or Provider reviewing the appeal may interview you or your designated representative and will make a decision on the appeal. Initial notice of the decision on the appeal including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision may be delivered orally to you but will be followed by a written notice of the determination within three days.

Filing Complaints with the *Texas Department of Insurance*

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the *Texas Department of Insurance* at P.O. Box 149091, Austin, Texas 78714-9091. The Department's telephone number is 1-800-252-3439.

The *Commissioner of Insurance* will investigate a complaint against us to determine our compliance with insurance laws within 60 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed.
- An on-site review is necessary.
- We, the Physician or Provider, or you do not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the control of the Department occur.

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

Prior Authorization

Prior authorization, included within the pre-service request, is a request to us for proposed services that will result in one of the following:

- A prior authorization;
- A confirmation of receipt of your request, when there are no clinical issues; or
- An Adverse Determination.

If you receive an Adverse Determination in response to your request for prior authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The Provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 calendar days after you receive the denial of a pre-service request for Benefits or the claim denial. The appeals process will be completed no later than 30 calendar days after the written request is received.

Please note that our decision is based only on whether Benefits are available under the Contract for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Adverse Determinations

An Adverse Determination is a decision that is made by us or our utilization review agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 8*: *Defined Terms*.

Appeals Determinations

Notice of Adverse Determinations

A utilization review agent will provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the Provider of record, followed by a letter within three working days notifying the patient and the Provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the Provider of record and the patient; or

- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to Emergency treatment as requested by a treating Physician or other health care Provider, notice will be provided to the treating Physician or other health care Provider no later than one hour after the time of the request.
- A utilization review agent will provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health care Benefits under the Contract no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your Provider of record receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your Provider of record may appeal the Adverse Determination orally or in writing.

If you, your designated representative or your Provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your Provider of record a one-page appeal form.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, 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 Benefit Determination.

We will complete the appeals process no later than the 30th calendar day after we receive your appeal.

If an appeal is upheld, within 10 working days of the appeal denial your treating Physician may request an additional review. A Physician who is of the same or similar specialty as the health care Provider who would typically manage the medical condition, procedure, or treatment will conduct the review. The specialty review will be completed within 15 working days from receipt of the request.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 calendar days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 calendar days after we receive your claim. If the extension is necessary because we have not received information from you or your Provider, we will specifically describe the information needed and allow 45 calendar days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your Provider respond to the request for additional information or the date the information was to be submitted.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

- We will notify you of the decision by the end of the next business day (not to exceed 72 hours if a holiday or weekend) following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs or intravenous infusions will include a review by a health care Provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care Provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.

- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Contract, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive any of the following:

- An Adverse Benefit Determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function
- An Adverse Benefit Determination involving the Involves denial of prescription drugs or intravenous infusions for which you are receiving Benefits.

  In addition, you must have filed a request for an expedited internal appeal.
- A final appeal decision, that either:
  - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all required documents and information we used in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Contract and how it may affect you. We administer the Contract under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Contract will cover or pay for the health care that you may receive. The Contract pays for Covered Health Care Services, which are more fully described in this EOC.
- The Contract may not pay for all treatments you or your Physician may believe are needed. If the Contract 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?

We have agreements in place that govern the relationship between us and Network Providers, some of which are affiliated Providers. Network Providers enter into an agreement 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.

What Is Your Relationship with Providers?

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, Cost Share Percentages, 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.

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. Your Co-payment and/or Cost Share Percentage 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 Cost Share Percentage 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 Cost Share Percentage as described in your *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; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

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/exchange or the telephone number on your ID card if you have any questions.

Fitness App Program

We may make a fitness app program available to you in combination with a non-UnitedHealthcare entity. The purpose of this program is to encourage you to take a more active role in managing your health and well-being. Participation in this program is voluntary. There are no financial benefits or incentives provided to you by this program.

The program provides access to a fitness digital app at no additional cost to you. Activities such as cycling, treadmill, strength, yoga, and meditation may be included in the fitness app.

To be eligible for this program, you must be a Covered Person who is 18 years or older as of your coverage effective or renewal date. We will notify you of the opportunity to enroll in the program. If you would like additional information regarding this program, you may call us at the telephone number on your ID card.

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 Cost Share Percentage.

Who Interprets Benefits and Other Provisions under the Contract?

We have the sole and exclusive authority to do all of the following:

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

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

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 Contract

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end the Contract.

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

No other change may be made to the Contract 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 Contract are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change the Contract or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Contract.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Contract 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 Contract, 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 Contract.
- Needed for medical review or quality assessment.
- Required by law or regulation.

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

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

Subrogation

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 Contract to treat your injuries. Under subrogation, the Plan 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.

Reimbursement

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical Benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you subject to *Section 140.005 of the Civil Practice and Remedies Code*. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Contract 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 Plan 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. We may pursue recovery against an underinsured or uninsured motorist for medical payments coverage if the Covered Person or their immediate family did not pay the premiums for the coverage.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
- Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Contacting us to obtain 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.
- 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 Contract, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries 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 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 reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Contract is governed by the applicable statute of limitations. We may also file a lawsuit to enforce our right of subrogation or reimbursement.
- 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 Contract, 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 Contract 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 Contract. 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 Plan’s subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Contract’s subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

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

Statements Made by Subscriber

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. A statement will not be used in a contest to void, cancel, non-renew coverage or reduce Benefits unless it is in a written enrollment application signed by the Subscriber that is or has been furnished to the Subscriber or the Subscriber's personal representative. We will not use any statement made by the Subscriber to void the Contract after it has been in force for two years unless it is a fraudulent statement.

What Is the Entire Contract?

This EOC, the *Schedule of Benefits*, the Subscriber's *Application* and any Riders and/or Amendments, make up the entire Contract.

Continuity of Care

If you are undergoing a course of treatment from a Network Physician or Provider at the time that Network Physician or Provider's contract terminates with us, you may be entitled to continue that care at the Network Benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care Provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability, acute condition, life-threatening illness, is pregnant from one-23 weeks, and undergoing a course of treatment for the Pregnancy from the Provider or facility, or is past the 24th week of Pregnancy. An additional special circumstance includes a Covered Person scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a surgery.

The treating Physician or Provider must submit the continuity of care request. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or Provider's contract is terminated, or nine months after the Physician or Provider's contract is terminated, if the Covered Person has been diagnosed as having a terminal illness at the time of termination. If the Covered Person is past the 24th week of Pregnancy at the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after delivery.

If you have questions regarding this continuity of care policy or would like help determining whether you are eligible for continuity of care Benefits, please contact us at www.myuhc.com/exchange or the telephone number on your ID card.

Section 8: Defined Terms

Adverse Determination - a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not Medically Necessary or appropriate, or are Experimental or Investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Air Ambulance - medical transport by helicopter or airplane.

Allowed Amounts - for Covered Health Care Services, incurred while the Contract 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, and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Care Center and a Residential Treatment Center for Children and Adolescents.

Ambulance - a vehicle for Medically Necessary transportation of sick and/or injured persons that is equipped and staffed to provide medical care during transport.

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

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

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

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The

Schedule of Benefits will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a pervasive developmental disorder defined by the most recent edition of the *Diagnostic and Statistical Manual (DSM)* as a condition marked by persistent deficits in social communication and social interaction and by restricted, repetitive patterns of behavior, interests or activities. This includes conditions present in the *ICD* such as *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 Contract.

Blood Product - includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Chemotherapy - charges incurred for the treatment of disease by chemical or biological antineoplastic agents or related supportive care regimens administered orally, intravenously or by injection. The chemical or biological antineoplastic agents or related supportive care regimens may be administered during a doctor's visit, home health care visit, or at an outpatient facility.

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.

Contract - the entire agreement issued to the Subscriber that includes all of the following:

- *Evidence of Coverage*
- *Schedule of Benefits*.
- Subscriber *Application*.
- Riders.
- Amendments.

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

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.

Cost Share Percentage - 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.

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 EOC under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this EOC 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 Contract. We use "you" and "your" in the Contract 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 - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

Dependent - the Subscriber's legal spouse, including common law spouse, or a child of the Subscriber or the Subscriber's spouse. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for who the Subscriber is a party in a suit seeking adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care or dental coverage is required through a *Qualified Medical Child Support Order*, dental support order or other court or administrative 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 year 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 Dependent includes a grandchild of the Subscriber, who is unmarried, under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

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

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 Service 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/exchange 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.

Diagnostic Imaging – An imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

- A subjective or objective abnormality detected by a Physician or patient in a breast;
- An abnormality seen by a Physician on a screening mammogram;
- An abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
- An individual with a personal history of breast cancer or dense breast tissue.

Dialysis - the process in which waste products are removed from the body by diffusion from one fluid compartment to another through a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis.

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 - a person who meets the eligibility requirements determined by the federal Health Insurance Marketplace. An Eligible Person must live within the Service Area.

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

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

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

Emergency Health Care Services - with respect to an Emergency:

A 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, or a comparable emergency facility, 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).

- Emergency Health Care Services include items and services otherwise covered under the Contract when provided by an Out-of-Network Provider or facility (regardless of the department of the Hospital in which the items are 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 Provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation.

    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) Any other conditions as specified by the Secretary.

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

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:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health 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 Emergency Medical Care Facility - a facility, structurally separate and distinct from a Hospital that receives an individual and provides Emergency care.

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

Functional or Physical Impairment - a Functional or Physical or Physiological Impairment which causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks;

- independent movement;
- performing basic life functions.

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.

Geographic Service Area - is the geographic area in which UnitedHealthcare of Texas, Inc., is licensed to arrange for medical and hospital services in the state of Texas. The UnitedHealthcare of Texas, Inc. Geographic Service Area includes the counties below:

Atascosa	Dallas	Fort Bend	Parker
Bexar	Denton	Galveston	Tarrant
Brazoria	El Paso	Harris	Travis
Collin	Ellis	Montgomery	Williamson

For a list of up-to-date UnitedHealthcare Network Physicians and health care professionals, you can access information by visiting our online Provider Directory at www.myuhc.com/exchange. If you would like additional information pertaining to our contracted Providers, you can call us at the telephone number on your ID card.

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.

Habilitative Services - 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.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S. Food and Drug Administration (FDA)* as Hearing Aids.

Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of the Contract, they are Hearing Aids).

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

Home Health Care Services - 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.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the Home Health Care.

Hospice Care - an integrated, structured, multi-disciplinary program of palliative care for Covered Persons facing the last six months of life due to a Terminal Illness.

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.

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.

Independent Review Organization (IRO) - an organization certified to hear appeals of Adverse Determinations.

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients.

Injury - traumatic 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. The total number of Home Health Care visits are limited to 60 visits per year and one visit equals up to four hours of skilled care services.

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.

Maintenance Program - A program with the goals to maintain the functional status or to prevent decline in function.

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

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

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

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to

apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com/exchange 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 139*4, et seq. and as later amended.

Mental Health Care Center - a tax supported institution of the *State of Texas*, including community centers for mental health and mental retardation services.

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.

Morbid Obesity Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity (from *National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity*).

Necessary Medical Supplies - medical supplies that are used in the home with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

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 Area - the Service Area, supplemented by any additional Providers we include as Network Area Providers. Contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information on the Network Area.

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-Emergency Ambulance Transportation - 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), closest Network Inpatient Rehabilitation Facility, or other closest Network sub-acute facility where the required Covered Health Care Services can be delivered.

Non-Emergent ER Services - health care services provided in the Emergent ER Services or emergency department of a Hospital or Alternate Facility that are not for an Emergency.

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.

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 how Out-of-Network Benefits apply. Plans under this Evidence of Coverage do not provide coverage for services provided by out-of-Network providers with the exception of Covered Health Care Services provided:

- In an Emergency.
- By out-of-Network radiologists, anesthesiologists, pathologists, neonatologists, and assistant surgeons when confined in a Network facility.
- As pre-authorized by us to be subsequently provided by an out-of-Network Physician, facility or other provider.

If you receive a bill from an out-of-Network provider after Covered Health Care Services were received in one of the above situations, you should contact us and we will work with the provider so that you are only responsible for your cost share amount.

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, 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 Contract.

Pregnancy - includes all of the following:

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

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

Presumptive Drug Test - qualitative test to determine the presence or absence of drugs or a drug class with results indicating a negative or positive result.

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

Private Duty Nursing - A provision of continuous Skilled Care from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in an individual's residence by a Home Health Agency, under the direction of the patient's Physician.

Provider - A licensed participating Provider who is contracted to provide medical services to Covered Persons (as defined within the Provider contract). The Provider may be a Hospital, pharmacy, other facility or a Physician or health care professional who has contractually accepted the terms and conditions as set forth.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from the federal Health Insurance Marketplace.

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

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

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

Rehabilitation -health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Recognized Amount - the amount which Co-payment, Cost Share Percentage and applicable deductible, is based on for the below Covered Health Care Services when provided by Out-of-Network Providers. The amount is based on either:

1) Applicable state law,
2) An *All Payer Model Agreement* if adopted, or
3) The qualifying payment amount as determined under applicable law for the following Covered Health Care Services:
    - 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 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.

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 - remote physiologic monitoring is 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. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship.

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.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - 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 EOC. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Contract except for those that are specifically amended in the Rider.

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated 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.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

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.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in the Contract 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. This does not include a facility primarily for rest, the aged, treatment of substance-related and addictive disorders services, or for care of behavioral health disorders.

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

Sub-Acute Facility - means a facility that provides intermediate care on short-term or long-term basis.

Subscriber - the person (who is not a Dependent) to whom the Contract is issued.

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.

Teledentistry Dental Service – a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth Service - a health care service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service - a health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Temporomandibular Joint Syndrome (TMJ) - Temporomandibular joint and muscle disorders are a collective group of conditions and symptoms characterized by pain and dysfunction to the temporomandibular joint and/or surrounding muscles that control jaw movement. Symptoms often include pain or tenderness to the temporomandibular joint, ear, neck, back, or shoulder pain, limited jaw mobility, or audible sounds with jaw movement.

Terminal Illness - in the context of hospice means a life expectancy, certified by two Physicians, of six months or less.

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

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

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

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

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 - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person’s life. Urgent Care is usually delivered in a walk-in setting and without an appointment. Urgent Care facilities are a location, distinct from a Hospital Emergency Department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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. Urgent Care facilities are a location, distinct from a Hospital Emergency Department, an office or a clinic.

Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Contract will be coordinated with those of any other plan that provides Benefits to you. The language in this section is specific to *Texas* law regarding coordination of 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, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred Provider Benefit plans and exclusive Provider Benefit plans; group insurance contracts that pay or reimburse for the cost of dental care; medical care components of individual and group and long-term care contracts; limited Benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group type coverage; medical Benefits coverage in automobile insurance contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: disability income protection coverage; the *Texas Health Insurance Pool*; workers' compensation insurance coverage; Hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental Benefit coverage; accident only coverage, specified accident coverage; school accident-type coverage that covers students for accidents only, including athletic injuries either on 24-hour basis or a to and from school basis; Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily Benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state mandated plan under Medicaid; a governmental plan that, by law, provides Benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

3. 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. A Contract may not reduce Benefits on the basis that: another Plan exists and the Covered Person did not enroll in that Plan; a person is or could have been covered under another Plan, except with respect to Part B of Medicare; or a person has elected an option under another Plan providing a lower level of Benefits than another option that could have been elected.

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, Cost Share Percentages 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 do not have negotiated fees and compute their Benefit payments on the basis of usual and customary fees, Allowed Amounts, 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 does not have negotiated fees and calculates its Benefits or services on the basis of usual and customary fees, Allowed Amounts, 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 must be the Allowable Expense for all Plans. However, if the health care Provider or Physician 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 health care Provider's or Physician'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 health care Provider or Physician's arrangements.

E. **Allowed Amount.** Allowed amount is the amount of a billed charge that a carrier determines to be covered for services provided by an Out-of-Network health care Provider or Physician. The allowed amount includes the carrier's payment and any applicable deductible, Co-payment, or Cost Share Percentage amounts for which the insured is responsible.

F. **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 coverages for services provided by other health care Providers and Physicians, except in cases of Emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent with the right to designate the primary residence of a child by a court order under the *Texas Family Code* or other applicable law, 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. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not, the Secondary Plan must pay or provide Benefits as if it were the Primary Plan when a Covered Person uses an Out-of-Network Physician, except for Emergency services or authorized referrals that are paid or provided by the Primary Plan.

E. When multiple contracts providing coordinated coverage are treated as a single Plan under this subchapter, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides Benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter.

F. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of this subchapter decide the order in which Secondary Plans' Benefits are determined in relation to each other. Each Secondary Plan must take into consideration the Benefits of the Primary Plan or Plans and the Benefits of any other Plan that, under the rules of this subchapter, has its Benefits determined before those of that Secondary Plan.

G. 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. An example includes a retired employee.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of Benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court order 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 order 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 order 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 order allocating responsibility for the child's health care expenses or health care coverage, the order of Benefits for the child are as follows:

         (a) The Plan covering the Custodial Parent.

         (b) The Plan covering the Custodial Parent's spouse.

         (c) The Plan covering the non-Custodial Parent.

         (d) The Plan covering the non-Custodial Parent's spouse.

   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of Benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

   d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

      (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of Benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled G.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 G.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, results in the total Benefits paid or provided by all Plans for the claim equaling 100 percent of the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, Benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 10: Outpatient Prescription Drugs

Network

This section provides Benefits for Prescription Drug Products.

Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under *Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Texas, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in *Section 8: Defined Terms*.

NOTE: The Coordination of Benefits provision in *Section 9: Coordination of Benefits* applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the Contract.

Introduction

Coverage Policies and Guidelines

Our Individual Exchange Pharmacy Management Committee (IEPMC) makes tier placement changes on our behalf. The IEPMC places *FDA-approved* Prescription Drug Products 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 up to monthly. These changes may happen without prior notice to you. In the event that a Prescription Drug Product that you have currently been prescribed moves to a higher tier or is removed from the Prescription Drug List (PDL), we will notify you no less than 60 days prior to the effective date of the change. Any prescription drug covered at the beginning of the plan year will continue to be covered throughout the plan year, regardless of whether the drug has been removed from the PDL. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement.

When considering a Prescription Drug Product for tier placement, the IEPMC 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/exchange or the telephone number on your ID card for the most up-to-date tier placement.

NOTE: Tier status for a Prescription Drug Product may be determined by accessing your Benefits for Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. The tier to which a Prescription Drug Product is assigned may change as detailed in the Contract.

Prescription Drug Products that are considered to be PPACA Zero Cost Share Preventive Care Medications will be provided at $0 cost share for Covered Persons.

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 *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 Cost Share Percentage, and any deductible that applies.

Submit your claim to:

OptumRx Claims Department,

PO Box 650540,

Dallas, TX 75265-0540

When Do We Limit Selection of Pharmacies?

To support optimal therapy for the management of members with pain and minimize the occurrence of drug abuse, diversion, and inappropriate use of opioids, if we determine that you may be using opioid-containing Prescription Drug Products and meet the following criteria, we may require you to choose one Network Pharmacy that will provide and coordinate all your future opioid prescription services.

If you meet the following criteria in the past 90 days, you may be required to choose a Network Pharmacy:

- At least nine (9) pharmacy claims for any opioid-containing products AND
- Opioid pharmacy claims from at least three (3) different prescribers OR
- Opioid pharmacy claims filled at least three (3) different pharmacies

Benefits will be paid for opioid-containing Prescription Drug Products only if you obtain these drugs at your 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.

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/exchange or the telephone number on your ID card.

Smart Fill Program

Certain Specialty Prescription Drug Products may be dispensed by a Network Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment. 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. A Network 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/exchange or the telephone number on your ID card.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so drugs that are refilled at the same frequency may be refilled concurrently.

On the initial synchronization, a pro-rated cost-share amount will be charged for a partial supply based on the number of days' supply of the drug actually dispensed if the following requirements are met:

- The pharmacy or prescribing Physician or health care Provider notifies us that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs.
- Is in the best interest of the Covered Person.
- The Covered Person agrees to the synchronization.

You may obtain additional information on these procedures by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Are Discounts and Incentives Available to You?

From time to time, we may make access available to discounts or incentive programs. Incentive programs may be available only to targeted populations and may include other incentives.

These discount and incentive programs are not insurance and are not an insurance Benefit or promise in the Contract. Your access to these programs is provided by us separately or independently from the Contract, and may be discontinued at any time. There is no additional charge for you to access these discount and incentive programs.

These programs may be offered or administered directly by us or through a third party vendor. If we receive any funds from a third party vendor in conjunction with making the discount or incentive programs available to you, we will use those funds to offset our costs of providing you access to the programs.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Cost Share Percentages and/or any applicable deductible 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, Cost Share Percentages and/or any applicable deductible requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

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.

Please see *Defined Terms* in this section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

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

Prescription Drugs from a Retail Network Pharmacy

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

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

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

Prescription Drug Products from a Mail Order Network Pharmacy

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

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

Please contact us at www.myuhc.com/exchange 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.

Prescription Drug Products from a Preferred Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a Preferred Retail Network Pharmacy.

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

Please contact us at www.myuhc.com/exchange 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 Preferred Retail Network Pharmacy.

Insulin and Insulin-Related Equipment Supplies

Coverage is provided for Emergency refills of insulin and insulin-related equipment supplies, in accordance with *Texas* law, in the same manner as for a nonemergency refills of insulin and insulin-related equipment or supplies.

Your Co-payment or Cost Share Percentage for insulin will not exceed the amount allowed by applicable law.

Prescription Eye Drops

Refills of prescription eye drops are covered if the Covered Person pays at the pharmacy the maximum amount allowed. The original prescription must state that additional quantities of the eye drops are needed, the refill may not exceed the total quantity of dosage units authorized by the prescribing Provider on the original prescription, including refills.

Refills may be dispensed on or before the last day of the prescribed dosage period:

- Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed.
- Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed.

- Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Exclusions

Exclusions from coverage listed in *Section 2: Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

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

1. Outpatient Prescription Drug Products obtained from an Out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. 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 will apply to any off-label drug that is excluded from coverage under this section as well as any drug that the *U.S. Food and Drug Administration (FDA)* has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening disease or condition if the drug:
    - Has been approved by the *FDA* for at least one indication.
    - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
        - A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
        - Substantially accepted peer-reviewed medical literature.
7. 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.
8. 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.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are otherwise provided in the Contract. This includes certain forms of vaccines/immunizations. This exclusion does not apply to *Depo Provera* and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are otherwise provided in the Contract.
12. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

13. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
14. Certain unit dose packaging or repackagers of Prescription Drug Products.
15. Medications used for cosmetic purposes.
16. 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.
17. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
18. Prescription Drug Products when prescribed to treat infertility.
19. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3, Tier 4, or Tier 5 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.
20. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 4.)
21. 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 will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are available as described in the Contract under *Diabetes Services* in *Section 1: Covered Health Care Services*.
22. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our IEPMC.
23. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
27. 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.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. 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 will occur no more often than annually on the Contract anniversary date. 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 for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

28. Dental products, including but not limited to prescription fluoride topicals.

29. 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) and
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products.

31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

32. 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.

33. Prescription Drug Products when prescribed to treat erectile dysfunction or sexual dysfunction.

Defined Terms

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.

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.

Individual Exchange Pharmacy Management Committee (IEPMC) - the committee that we designate for placing Prescription Drug Products into specific tiers.

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 IEPMC.
- December 31st of the following calendar year.

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, Cost Share Percentage or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

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/exchange or the telephone number on your ID card.

Preferred Retail Network Pharmacy - a retail 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 (PDL) - 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 modification. These changes will occur no more often than annually on the Contract anniversary date. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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 appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Contract, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in 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, excluding 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. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com/exchange 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 or pricing agreed to by the pharmacy and any third party. This fee includes any applicable dispensing fee and sales tax.

Step Therapy Exception Requests

When a step therapy requirement applies to a Prescription Drug Product, your Provider may request an exception.

- For non-urgent step therapy exception requests, a review will be completed within 72 hours once all information needed to process the request has been received. If the exception request is not denied within 72 hours, then the request will be considered granted.
- For urgent step therapy exception requests, a review will be completed within 24 hours once all the information needed to process the request has been received. If the exception request is not denied within 24 hours, then the request will be considered granted.

If your step therapy exception request is denied, please refer to *Section 6: Questions, Complaints and Appeals* for additional information on appealing an Adverse Determination.

Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Cost Share Percentage 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*.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization* (*IRO*) will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

Section 11: Pediatric Dental Care Services

Network

How Do You Use This Document?

This section provides Benefits for Covered Dental Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under *Defined Terms for Pediatric Dental Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Texas, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in *Section 8: Defined Terms*.

Accessing Pediatric Dental Care Services

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental Care Services from a Network Dental 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 Care Services to be paid, you must obtain all Covered Dental Care 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 a 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.

Benefits are not available for Dental Care Services that are not provided by a Network Dental Provider, unless as a result of an Emergency or if we refer you to an Out-of-Network Provider.

What Are Covered Dental Care Services?

You are eligible for Benefits for Covered Dental Care Services listed in this section if such Dental Care Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Care Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this section.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must

provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of Benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Contract. 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 Prior Authorization Apply?

Prior authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a prior authorization before Dental Care Services are provided. It is your Dental Provider's responsibility for obtaining a prior authorization. If you do not obtain a prior authorization, we have a right to deny your claim for failure to comply with this requirement.

Benefits for Pediatric Dental Care Services

Benefits are provided for the Dental Care 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 *Pediatric Dental Exclusions* of this section.

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 Care Services and Benefits will not be payable.

Annual Deductible

Benefits for Pediatric Dental Care Services provided under this section are subject to the Annual Deductible stated in the *medical Schedule of Benefits*.

Out-of-Pocket Limit - any amount you pay in Cost Share Percentage for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Benefits

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

NOTE: When Covered Health Care Services are provided by an Indian Health Service Provider, your cost share may be reduced.

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)	
Evaluations (Checkup Exams) *Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.* D0120 - Periodic oral evaluation. D0140 - Limited oral evaluation - problem focused. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. D0150 - Comprehensive oral evaluation. D0180 - Comprehensive periodontal evaluation. *The following service is not subject to a frequency limit.* D0160 - Detailed and extensive oral evaluation - problem focused.	None
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Complete series (including bitewings). D0709 - Intraoral - complete series of radiographic images - image capture only.	None
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film. D0230 - Intraoral - periapical - each additional film.	None

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D0240 - Intraoral - occlusal film. D0706 - Intraoral - occlusal radiographic image - image capture only. D0707 - Intraoral - periapical radiographic image - image capture only.	
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film. D0272 - Bitewings - two films. D0274 - Bitewings - four films. D0277 - Vertical bitewings. D0708 - Intraoral - bitewing radiographic image - image capture only.	None
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image. D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only. D0704 - 3-D Photographic image - image capture only.	None
The following services are limited to two images per calendar year. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray. D0350 - Oral/Facial photographic images. D0391 - Interpretation of diagnostic image. D0470 - Diagnostic casts. D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not 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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
Dental Prophylaxis (Cleanings) *The following services are limited to two times every 12 months.* D1110 - Prophylaxis - adult. D1120 - Prophylaxis - child.	None
Fluoride Treatments *The following services are limited to two times every 12 months.* D1206 and D1208 - Fluoride.	None
Sealants (Protective Coating) *The following services are limited to once per first or second permanent molar every 36 months.* D1351 - Sealant - per tooth - unrestored permanent molar. D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None
Space Maintainers (Spacers) *The following services are not subject to a frequency limit.* D1510 - Space maintainer - fixed, unilateral - per quadrant. D1516 - Space maintainer - fixed - bilateral maxillary. D1517 - Space maintainer - fixed - bilateral mandibular. D1520 - Space maintainer - removable, unilateral - per quadrant. D1526 - Space maintainer - removable - bilateral maxillary. D1527 - Space maintainer - removable - bilateral mandibular. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular.	None

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1556 - Removal of fixed unilateral space maintainer - per quadrant. 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 - (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* D2140 - Amalgams - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces, primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.	50%
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior. D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior.	50%
Crowns/Inlays/Onlays - (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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four surfaces. D2740 - Crown - porcelain/ceramic substrate. D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. D2753 - Crown - porcelain fused to titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2930 - Prefabricated stainless steel crown - primary tooth. D2931 - Prefabricated stainless steel crown - permanent tooth. *The following services are not subject to a frequency limit.* D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement inlay. D2920 - Re-cement crown.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
The following service is not subject to a frequency limit. D2940 - Protective restoration.	50%
The following service is limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain crown - primary. D2950 - Core buildup, including any pins.	50%
The following service is limited to one time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to crown.	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%
The following service is not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair. D2982 - Onlay repair. D2983 - Veneer repair. *The following service is limited to one time per tooth every 36 months.* D2990 - Resin infiltration/smooth surface.	50%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration).	50%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
The following service is not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	50%
The following service is not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration). D3320 - Bicuspid root canal (excluding final restoration). D3330 - Molar root canal (excluding final 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.	50%
The following service is not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification - interim medication replacement. D3353 - Apexification/recalcification - final visit.	50%
The following service is not subject to a frequency limit. D3355, D3356 & D3357 - Pulpal regeneration.	50%
The following service is not subject to a frequency limit. D3410 - Apicoectomy/periradicular - anterior. D3421 - Apicoectomy/periradicular - bicuspid. D3425 - Apicoectomy/periradicular - molar.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D3426 - Apicoectomy/periradicular - each additional 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 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 service is not subject to a frequency limit. D3450 - Root amputation - per root.	50%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including root canal therapy.	50%
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth. D4211 - Gingivectomy or gingivoplasty - one to three teeth. D4212 - Gingivectomy or gingivoplasty - with restorative procedures, per tooth.	50%
The following service is limited to one every 36 months. D4240 - Gingival flap procedure, four or more teeth.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue.	50%
The following service is limited to one every 36 months. D4260 - Osseous surgery. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. D4263 - Bone replacement graft - first site in quadrant.	50%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure. D4277 & D4278 - Free soft tissue graft procedure.	50%
The following service is not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth. D4275 - Soft tissue allograft. D4277 - Free soft tissue graft - first tooth. D4278 - Free soft tissue graft - additional teeth.	50%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis.	50%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance.	50%
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary. D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular. D5211 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
(including retentive/clasping materials, rests and teeth). D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary. D5411 - Adjust complete denture - mandibular. D5421 - Adjust partial denture - maxillary. D5422 - Adjust partial denture - mandibular. D5511 & D5512 - Repair broken complete denture base. D5511 - Repair broken complete denture base - mandibular. D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture. D5611 & D5612 - Repair resin denture base. D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5621 & D5622 - Repair cast framework.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D5621 - Repair cast partial framework - mandibular. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken retentive/clasping materials - per tooth. D5640 - Replace broken teeth - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture.	
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. D5710 - Rebase complete maxillary denture. D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5730 - Reline complete maxillary denture (direct). D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic full denture (per arch).	50%
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary).	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D5851 - Tissue conditioning (mandibular).	
Bridges (Fixed partial dentures) - (Subject to payment of the Annual Deductible.)	
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 to predominately base metal. D6242 - Pontic - porcelain fused to noble metal. D6243 - Pontic - porcelain fused to titanium and titanium alloys. D6245 - Pontic - porcelain/ceramic.	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis. D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	50%
The following services are not subject to a frequency limit. D2610, D2620, D2630, D2642, D2643 D2644 - Inlay/onlay - porcelain/ceramic. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three or more surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four or more surfaces.	50%
The following services are limited to one time every 60 months.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D6740 - Retainer crown - porcelain/ceramic. D6750 - Retainer crown - porcelain fused to high noble metal. D6751 - Retainer crown - porcelain fused to predominately base metal. D6752 - Retainer crown - porcelain fused to noble metal. D6753 - Retainer crown - porcelain fused to titanium and titanium alloys. D6780 - Retainer crown - 3/4 cast high noble metal. D6781 - Retainer crown - 3/4 cast predominately base metal. D6782 - Retainer crown - 3/4 cast noble metal. D6783 - Retainer crown - 3/4 porcelain/ceramic. 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 fixed partial denture.	50%
The following services are not subject to a frequency limit. D2950 - Core build up for retainer, including any pins. D6980 - Fixed partial denture repair necessitated by restorative material failure.	50%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D7140 - Extraction, erupted tooth or exposed root.	
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony. D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots. D7251 - Coronectomy - intentional partial tooth removal.	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	50%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth.	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - per quadrant.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant.	
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible).	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess. D7910 - Suture of recent small wounds up to 5 cm. D7921 - Collect - apply autologous product. D7953 - Bone replacement graft for ridge preservation - per site. D7961 - Buccal/labial frenectomy (frenulectomy). D7962 - Lingual frenectomy (frenulectomy). D7971 - Excision of pericoronal gingiva.	50%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
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. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure.	50%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia first 30 minutes. D9223 - Dental sedation/general anesthesia each additional 15 minutes. D9222 - Deep sedation/general anesthesia - first 15 minutes. D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D9239 - Intravenous conscious sedation/analgesia - first 30 minutes. D9243 - Intravenous conscious sedation/analgesia - each additional 15 minutes. D9610 - Therapeutic drug injection, by report.	
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	50%
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.	50%
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. D6010 - Endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Eposteal implant. D6050 - Transosteal implant, including hardware. D6110 & D6111 - Implant supported complete denture. D6112 & D6113 - Implant supported partial denture. D6055 - Connecting bar implant or abutment supported. D6056 - Prefabricated abutment. D6057 - Custom abutment. D6058 - Abutment supported porcelain ceramic crown.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D6059 - Abutment supported porcelain fused to high noble metal. D6060 - Abutment supported porcelain fused to predominately base metal crown. D6061 - Abutment supported porcelain fused to noble metal crown. D6062 - Abutment supported cast high noble metal crown. D6063 - Abutment supported cast predominately base metal crown. D6064 - Abutment supported porcelain/ceramic crown. D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys. D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture. D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture. D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture. D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture. D6072 - Abutment supported retainer for cast high noble metal fixed partial denture. D6073 - Abutment supported retainer for predominately base metal fixed partial denture. D6074 - Abutment supported retainer for cast metal fixed partial denture. D6075 - Implant supported retainer for ceramic fixed partial denture. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys.	

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D6077 - Implant supported retainer for metal FPD - high noble alloys. D6114 & D6115 - Implant/abutment supported fixed partial denture for completely edentulous arch. D6116 & D6117 - Implant/abutment supported fixed partial denture for partially edentulous arch. D6080 - Implant maintenance procedure. 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. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys. D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6090 - Repair implant prosthesis. D6091 - Replacement of semi-precision or precision attachment. D6095 - Repair implant abutment. D6096 - Remove broken implant retaining screw. D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys. D6100 - Implant removal.	

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous peri-implant defect. D6103 - Bone graft peri-implant defect. D6104 - Bone graft implant replacement. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular. D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys. D6190 - Implant index. D6191 - Semi-precision abutment - placement. D6192 - Semi-precision attachment - placement. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome*, *Treacher-Collins Syndrome, Pierre-Robin Syndrome*, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.	

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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.	
The following services are not subject to a frequency limitation as long as Benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8050 - Interceptive orthodontic treatment of the primary dentition. D8060 - Interceptive orthodontic treatment of the transitional dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy. D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular. D8698 - Re-cement or re-bond fixed retainer - maxillary. D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary.	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?	**Benefits** **The Amount You Pay Which May Include a Cost Share Percentage or Co-Payment.**
D8702 - Repair of fixed retainer, includes reattachment - mandibular.	

Pediatric Dental Exclusions

Except as may be specifically provided in this section under *Benefits for Pediatric Dental Care Services*, Benefits are not provided under this section for the following:

1. Dental Care Services received from an Out-of-Network Dental Provider, unless you receive Dental Care Services from an Out-of-Network Provider as a result of an Emergency or if we refer you to an Out-of-Network Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section under *Benefits for Pediatric Dental Care Services*.
3. Dental Care Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to Provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (*TMJ)*, either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.

15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours' notice, telephone consultations and sales tax.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section to the Contract.
17. Dental Care Services otherwise covered under the Contract, but provided after the date individual coverage under the Contract ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Contract ends.
18. Services rendered by a Provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered outside of the United States.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
25. Services that exceed the frequency limitations as identified in this section.

Defined Terms for Pediatric Dental Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Contract:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Contract is in effect, are our contracted fee(s) for Covered Dental Care Services with that Provider.

Covered Dental Care Service - a Dental Care Service or Dental Procedure for which Benefits are provided under this section.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Care Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Care Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Contract 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 Care Services and supplies under this section 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 Care 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 Care Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Section 12: Pediatric Vision Care Services

Network

How Do You Use This Document?

This section provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under *Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Texas, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in *Section 8: Defined Terms*.

Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the Provider locator service at 1-866-811-2704. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhc.com/exchange.

Benefits are not available for Vision Care Services that are not provided by a UnitedHealthcare Vision Network Vision Care Provider.

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-Pocket Limit - any amount you pay in Cost Share Percentage for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this section are subject to any Annual Deductible stated in the medical *Schedule of Benefits.*

What Are the Benefit Descriptions?

Benefits

Benefit limits are calculated on a calendar 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 Cost Share Percentage 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.

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.

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

NOTE: When Covered Health Care Services are provided by an Indian Health Service Provider, your cost share may be reduced.

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		50% Not subject to payment of the Annual Deductible.
• Bifocal		50%

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
		Not subject to payment of the Annual Deductible.
• Trifocal		50% Not subject to payment of the Annual Deductible.
• Lenticular		50% Not subject to payment of the Annual Deductible.
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Frames	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		50% Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $130 - 160.		50% Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $160 - 200.		50% Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $200 - 250.		50% Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost greater than $250.		50% Not subject to payment of the Annual Deductible.
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	Once every 12 months	None Not subject to payment of the Annual Deductible.

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Covered Contact Lens Formulary	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.
Necessary Contact Lenses	Limited to a 12 month supply.	50% Not subject to payment of the Annual Deductible.
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	
• Low vision testing		None Not subject to payment of the Annual Deductible.
• Low vision therapy		25% Not subject to payment of the Annual Deductible.

Pediatric Vision Exclusions

Except as may be specifically provided in this section under *Benefits for Pediatric Vision Care Services*, Benefits are not provided under this section for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Contract.
2. Vision Care Services received from a non-UnitedHealthcare Vision Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in *Section 1: Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Orthoptics or vision therapy training and any associated supplemental testing.
9. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).

10. Contact lenses if an eyeglass frame and eyeglass lenses are received in the same calendar year.
11. Eyeglass frame and eyeglass lenses if contact lenses are received in the same calendar year.
12. Services or treatments that are already excluded in the General Exclusions and Limitations section of this EOC.

Claims for Low Vision Care Services

When obtaining low Vision Care Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in *Section 5: How to File a Claim* applies to Vision Care Services provided under this section, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Care Services

To file a claim for reimbursement for low Vision Care Services, you must provide all of the following information:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of this EOC:

Covered Contact Lens Formulary - 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 Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Contract.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this section under *Benefits for Pediatric Vision Care Services.*

Geographic Service Area Map