OPTIMUM CHOICE, INC.

Individual Exchange Benefit Plan Medical Policy

800 King Farm Boulevard

Rockville, MD 20850

(877) 265-9199

Virginia

Policy Number - [999-999-999]

Total Premium - [$XXXX.XX]

Policyholder - [John Doe]

Premium Mode - [Monthly] [Quarterly]

Effective Date - [Month Day, Year]

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this Policy, please contact us at the address or telephone number stated above. If you have been unable to contact or obtain satisfaction from us, you may contact the Virginia Bureau of Insurance at:

State Corporation Commission

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

(804) 371-9741 (local or out-of-state calls)

(804) 371-9944 (fax number)

(800) 552-7945 (in-state toll free number)

(877) 310-6560 (national toll free number)

E-mail: bureauofinsurance@scc.virginia.gov

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Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us or the Virginia Bureau of Insurance, have your Policy number available.

We recommend that you familiarize yourself with our complaint/appeal procedure and make use of it before taking any other action.

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy 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 Policy, except that your coverage may end for events as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This Policy 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. At least 31 days' notice of any plan to take an action or make a change permitted by this paragraph will be mailed to you at your last address as shown in our records.

On January 1 of each calendar year, we may change the rate table used for this Policy form. 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 the Policy 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 75 days' notice of any plan to take an action or make a change permitted by this paragraph 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 Policy

Please read this Policy. 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 Policy will then be void from its start.

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

Joseph Ochipinti, President and CEO

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What Is the Policy?

This Policy is a legal document between Optimum Choice, Inc. and you and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's *Application* and payment of the required Premium.

This Policy includes:

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

Can This Policy Change?

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

Other Information You Should Have

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

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

We are delivering this Policy in The Commonwealth of Virginia. This Policy is governed by The Commonwealth of Virginia law.

We are subject to regulation in this Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance (pursuant to Title 38.2) and the Virginia Department of Health (pursuant to Title 32.1).

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Introduction to Your Policy

This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

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

Review the Benefit limitations of this Policy 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 Policy 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 *Policy* and any summaries provided to you, this *Policy* 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.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which in your opinion we have not satisfactorily addressed, you may contact the Office of the Managed Care Ombudsman for assistance as indicated below:

Office of the Managed Care Ombudsman

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

Phone number: (877) 310-6560

Fax number: (804) 371-9944

Ombudsman@scc.virginia.gov

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Your Responsibilities

Enrollment and Required Premiums

Benefits are available to you if you are enrolled for coverage under this Policy. 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 this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or a Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

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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. When prior authorization is the responsibility of an in Network provider, any reduction or denial of Benefits will not affect you. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or Facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. Amounts which you are required to pay, as shown in the Schedule of Benefits, are based on Allowed Amounts. The Allowed Amounts provision near the end of the Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

We will keep Out-of-Pocket Limit records and will notify you no later than 30 days after such limit is reached. We will not charge any further Annual Deductible, Co-payments or Co-insurance for the applicable benefit period when Out-of-Pocket Limit are reached and will promptly refund any excess Annual Deductible, Co-payments or Co-insurance paid.

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 Policy's exclusions.

Show Your ID Card

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

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, as a result of an Emergency or we refer you to an out-of-Network provider, we pay out-of-Network providers directly. However, if you have already paid the out-of-Network provider, we will accept a request for payment submitted by you. If you submit a request for payment, you must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

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

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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 Policy, 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 this Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines 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.

Any exercise of such discretion is subject to your right of appeal and external review as stated below in *Section 6: Questions, Complaints and Appeals*.

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

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reimbursement policies) and the billed charge. However, except for Emergency Services and Emergency air ambulance services provided to a Covered Person or non-Emergency Services provide to a Covered Person at a Network Facility by an out-of-Network provider, 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. Out-of-Network providers may not bill you for (i) Emergency services provided to an enrollee or (ii) non-emergency services provided to an enrollee at a Network Facility if the non-emergency services involve Surgical or Ancillary Services provided by an out-of-Network provider. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider at the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable methodology. Reimbursement levels for Emergency Health Care Services and non-emergency services provided to at a Network Facility by an out-of-Network provider will be based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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.

Standing Referrals

In accordance with state law, we provide direct access without need for Primary Care Physician coordination or referral to:

- Network Physicians who are obstetrician/gynecologists for any female Covered Person age 13 and above;
- Board-certified Network Physicians in pain management or oncology who are authorized to provide cancer pain management services under the Policy and whom a Covered Person diagnosed with cancer has selected.

For the purposes of this paragraph, "special medical condition" means a condition or disease that is:

- life-threatening, degenerative, or disabling; and
- requires specialized medical care over a prolonged period of time.

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OPTIMUM CHOICE, INC.

Schedule of Benefits

UHC Gold Advantage+ Extra ($3 Walgreens T1 Preferred Rx + Dental + Vision + 3 $0 Virtual Urgent Care Visits)

VA0012, $2,250

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 us 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 us for services from that other Physician. The electronic referral must be received by us before the services are rendered. If you see a Network Physician without an electronic referral for 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 services received from the Network Physician without the required referral, including all related services received and Facility charges. 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.

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Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from an Optimum Choice, Inc. Individual Exchange Benefit Plan Network provider. You can confirm that your provider is an Optimum Choice, Inc. 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 an Optimum Choice, Inc. 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 for Surgical and Ancillary Services provided at 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.*

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 an Optimum Choice, Inc. Policy.

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 prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

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

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.

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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 Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided in the Policy 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 individual Covered Person on a family plan will have to pay an Annual Deductible higher than the per Covered Person Annual Deductible for Covered Health Care Services. Charges for Covered Health Care Services incurred by remaining Covered Persons on the family plan who have not met their per Covered Person Annual Deductible will continue to accrue towards both their per Covered Person Annual Deductible and the family Annual Deductible. When the total amount of expenses for Covered Health Care Services accruing towards the family Annual Deductible meets the family Annual Deductible, all Covered Persons on the family plan will have satisfied Annual Deductible obligations under this Policy, regardless of whether an individual Covered Person has met his or her per Covered Person Annual Deductible.	$2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you or someone on your behalf pays per year, to the extent allowed by law, for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided in the Policy under the *Outpatient Prescription Drug Section*, the *Pediatric Vision Care Services Section,* and the *Pediatric Dental Care Services Section.*	$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.

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Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. No individual Covered Person on a family plan will have to pay an Out-of-Pocket Limit higher than the per Covered Person Out-of-Pocket Limit. Total combined out-of-pocket expenses for all Covered Persons on a family plan shall not exceed the family Out-of-Pocket Limit, regardless of the number of family members who contribute to those out-of-pocket expenses. 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. • Co-payments or Co-insurance for Covered Health Service provided under the *Adult Vision Care Services section*. • Co-payments or Co-insurance for Covered Health Care Services provided under the *Adult Dental Care Services section*.	

Co-payment
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.

Co-insurance
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

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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 this Policy.
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the

end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
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:* 30%	Yes	Yes
	Air Ambulance: 30%	Yes	Yes
	Emergency Ambulance Services - Water: 30%	Yes	Yes
Non-Emergency Ambulance Transportation Ground or Air Ambulance or water, as we determine appropriate.	*Ground Ambulance:* 30%	Yes	Yes
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:* 30%	Yes	Yes

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Admin. [Para]	*Non-Emergency Ambulance Transportation - Water:* 30%	Yes	Yes
2. Autism Spectrum Disorder			
	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. Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	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*.		
4. Dental Anesthesia and Services for Medical Treatments			
	30%	Yes	Yes
5. Dental Services - Accident Only			
	30%	Yes	Yes
6. Diabetes Services			
Diabetes Self-Management and Educational Services	Admin. [Para] 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.*		
7. Durable Medical Equipment (DME)			
You must purchase or rent the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	30%	Yes	Yes

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8. 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 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, Co-insurance 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.*	After you pay $500 per visit and satisfy the Annual Deductible you will pay none of the remaining Allowed Amount	Yes	Yes
9. Enteral Nutrition			
	30%	Yes	Yes
10. Family Planning 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.*		
11. Habilitative Services			
Outpatient therapies are limited per year as follows: • 30 visits of any combination of physical therapy or occupational therapy.	*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.*		

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• 30 visits of speech therapy. • 30 visits for manipulative treatment. The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit. When you get physical, occupational or speech therapy, in the home, the home health care visit limit will apply instead of the therapy services limits listed above. Note: Benefits for Early Intervention Services and services for the treatment of Autism Spectrum Disorder are not subject to the above annual limits.			
	Outpatient 30%	Yes	Yes
	Early Intervention Services 30%	Yes	Yes
12. Home Health Care			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. Limitations: Covered expenses for home health services will be limited to a maximum of 100 visits per covered person per calendar year.	30%	Yes	Yes

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This limit does not apply to home infusion therapy or home dialysis. Private-duty nursing services are limited to 16 hours per year.			
For the administration of intravenous infusion, you must receive services from a Network provider we identify.			
13. Hospice Care			
The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit.	30%	Yes	Yes
14. Hospital - Inpatient Stay			
	30%	Yes	Yes
15. Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient:	$15 per service at 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:	30% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
16. Manipulative Treatment			
Limited to 30 visits per year. Applies separately for rehabilitative and habilitative services.	30%	Yes	Yes
17. Major Diagnostic and Imaging - Outpatient			
	30% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes

SAMPLE

18. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient 30%	 Yes	 Yes
When outpatient visits are subject to payment of a Co-payment, the Co-payment will not exceed 50% of Allowed Amounts. Telehealth services available	*Outpatient* 30% *Office Visit* $50 per visit	 Yes Yes	 Yes No
19. Necessary Medical Supplies			
	30%	Yes	Yes
20. Orthotics			
	30%	Yes	Yes
21. 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 *Section 10: Outpatient Prescription Drugs*.	30%	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in Network Facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	30%	Yes	Yes
23. Physician's Office Services - Sickness and Injury			

SAMPLE

	$25 per visit for services provided by your Primary Care Physician	Yes	No
	$50 per visit for services provided by a Network Specialist or other Network Physician	Yes	No
24. Pregnancy - Maternity Services			
In accordance with Virginia law and as described in the Policy, Benefits are provided for a home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital.	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Breast pumps	None	Yes	No
25. Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
26. Prosthetic Devices			
Benefits are limited to one wig per year as needed following cancer treatment.	30%	Yes	Yes
27. 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*.		
Cleft Lip and Cleft Palate Treatment	30%	Yes	Yes
28. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 30 visits for any combination of physical therapy and occupational therapy.	*Outpatient* 30%	Yes	Yes

SAMPLE

• 30 visits of speech therapy. • Unlimited visits for pulmonary and cardiac rehabilitation therapy. • 30 visits for manipulative treatment. The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit. When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the home health care visit limit will apply instead of the therapy services limits listed above.			
29. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	30%	Yes	Yes
30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 100 days per Inpatient Stay. Limit will be any combination of Skilled Nursing or IP Rehab Services.	30%	Yes	Yes
31. Surgery - Outpatient			
	30% at an ambulatory surgical center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based surgical center	Yes	Yes
32. Telehealth			
	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*.		

SAMPLE

33. Temporomandibular Joint Syndrome (TMJ)			
	30%	Yes	Yes
34. Therapeutic Treatments - Outpatient			
Including dialysis/chemotherapy and infusion services.	30%	Yes	Yes
Home Treatment of Hemophilia and Congenital Bleeding Disorders Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment (DME), or Necessary Medical Supplies.	30%	Yes	Yes
35. Transplantation Services			
Transplantation services must be received from a Designated Provider. Covered expenses for lodging and ground transportation will be limited to the current limits set forth in the Internal Revenue Code.	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.*		
36. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products	$50 per visit	Yes	No

SAMPLE

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*.			
37. 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* None for the first 3 visits in a year; $25 per visit for any subsequent visits in that year	Yes	No
	Urgent Care None for the first 3 visits in a year; $25 per visit for any subsequent visits in that year	Yes	No
38. Vision Correction After Surgery or Accident			
	30%	Yes	Yes

SAMPLE

Continuity of Care

If you are under the care of a Network provider and the Network provider caring for you is terminated from the Network for reasons other than cause, we can arrange, at your request, for continuation of Covered Health Care Services rendered by the terminated provider for the time periods shown below. Co-payments, Co-insurance, deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us. The terminated provider will be reimbursed in accordance with our agreement with the provider existing immediately before the provider's termination of participation.

Medical conditions and time periods for which treatment by a terminated Network Physician will be covered under the Policy are:

- An active course of treatment begun before the provider terminated: Treatment by the terminated provider may continue for at least 90 days.

- A Pregnancy that has reached the second or third trimester: Treatment by the terminated provider may continue until the postpartum services related to the delivery are completed.
- A specified course of treatment for a terminal illness or a related condition: Continuity of care may last for the remainder of the Covered Person's life or until coverage under the Policy terminates.

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 ***Surgical or Ancillary Services received at 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 Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy*.
- 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 Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy.*
- 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 Network Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in this *Policy*.

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 Network Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

SAMPLE

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 Network Facilities from out-of-Network Physicians when such services are Surgical or Ancillary Services, the Allowed Amount is based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

IMPORTANT NOTICE: Out-of-Network Facility-based Physicians may not bill you for any difference between the Physician's billed charges and the Allowed Amount described here. For Surgical or Ancillary Services, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy*.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

IMPORTANT NOTICE: Out-of-Network providers may not bill you for any difference between the provider's billed charges and the Allowed Amount described here. You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy.*

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 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 Network Co-payment, Co-insurance 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, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

SAMPLE

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.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care Facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network Facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

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

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network Facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

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.

SAMPLE

Outpatient Prescription Drug

Optimum Choice, Inc.

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 Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

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

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under Pharmaceutical Products – Outpatient in your Policy, regardless of tier placement.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment and/or Co-insurance may change 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 Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Refill Synchronization

Prescriptions dispensed by a network pharmacy for a partial supply of a covered prescription drug, in order to synchronize your medications, will be covered at a prorated cost-sharing rate.

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 Service.

SAMPLE

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 the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, the amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance 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 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 Policy 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.

However, you or your prescriber may request an override exception and we will provide determination no later than 72 hours after receipt of the request for the step therapy override exception. An expedited exception request will be reviewed with a determination provided no later than 24 hours following the request.

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.

SAMPLE

What Do You Pay?

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

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your Policy before Benefits for Prescription Drug Products under this Policy are available to you unless otherwise allowed under this Policy.

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

The Co-payment amount or Co-insurance 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 Policy may not be included in calculating any Out-of-Pocket Limit stated in your Policy:

- 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.

SAMPLE

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 Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the IEPMC's tier placement of a Prescription Drug Product. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. **Special Programs**: We may have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program**: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription	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 Co-insurance. • 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 Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

SAMPLE

Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist**: You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com/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.	

SAMPLE

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 Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
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 Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. For insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed $50 for an individual prescription of up to a 30-day supply. For covered prescription hormonal contraceptives, up to a 12-month supply may be dispensed or furnished at one time.	Your Co-payment and/or Co-insurance 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: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 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: 40% 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	Your Co-payment and/or Co-insurance 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 or Preferred Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $6 per Prescription Order or Refill.

SAMPLE

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. For insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed $150 for an individual prescription of up to a 90-day supply. For covered prescription hormonal contraceptives, up to a 12-month supply may be dispensed or furnished at one time. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	For a Tier 2 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $100 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: 40% 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.
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 and/or Co-insurance 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: $3 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $15 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 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: 40% of the Prescription Drug Charge per Prescription Order or Refill after you meet the Annual Deductible.

SAMPLE

	For up to a 90-day supply at a Preferred Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $6 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $30 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $100 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: 40% 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.

SAMPLE

Schedule of Benefits: Pediatric Dental Care Services

Annual Deductible

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

Out-of-Pocket Limit - any amount you pay in Coinsurance for Pediatric Dental Care Services under this Policy 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.

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 Co-insurance 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. D0145 – Oral evaluations for a patient under three years of age and counseling with primary caregiver. D0150 - Comprehensive oral evaluation.	None
Intraoral Radiographs (X-ray) Limited to 1 series of films per 60 months in combination with D0330. D0210 - Complete series (including bitewings).	None
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film. D0230 - Intraoral - periapical - each additional film.	None
The following services are limited to two images per 12 months.	None

SAMPLE

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 Co-insurance or Co-Payment.**
D0240 – Intraoral – occlusal film.	
The following services are not subject to a frequency limit. D0250 – Extraoral – first film. D0260 – Extraoral – each additional film. D0270 – Bitewings – single film.	None
Any combination of the following services is limited to 1 *series of films per 12 months.* D0272 - Bitewings - two films. D0273 – Bitewings – three films. D0274 - Bitewings - four films.	None
The following service is limited to one per 60 months in combination with D0210. D0330 - Panoramic radiograph image.	None
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray. D0470 - Diagnostic casts.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
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 per lifetime. D1351 - Sealant - per tooth - unrestored permanent molar.	None

SAMPLE

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 Co-insurance or Co-Payment.**
Space Maintainers (Spacers) *The following services are limited to one every 24 months.* 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. *The following services are not subject to a frequency limit.* D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. 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.	None
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.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D2160 - Amalgams - three surfaces, primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.	
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. D2391 - Resin-based composite – one surface, posterior. D2392 - Resin-based composite – two surfaces, posterior. D2393 - Resin-based composite – three surfaces, posterior. D2394 - Resin-based composite – four or more surfaces, posterior.	30%
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)	
The following services are subject to a limit of one time every 60 months. D2644 - Onlay - porcelain/ceramic – four or more surfaces. D2710 - Crown - resin-based composite (indirect). D2720 - Crown - resin with high noble metal. D2721 - Crown - resin with predominantly base metal. D2722 - Crown - resin with noble metal. D2740 - Crown - porcelain/ceramic substrate.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. 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. The following services are not subject to a frequency limit. D2390 – Resin-based composite crown, anterior. D2915 – Re-cement or re-bond indirectly fabricated or prefabricated post and core. D2920 - Re-cement crown. D2929 - Prefabricated porcelain/ceramic crown – primary tooth. D2930 - Prefabricated stainless steel crown – primary tooth. D2931 - Prefabricated stainless steel crown – permanent tooth. D2932 - Prefabricated resin crown. D2933 – Prefabricated stainless steel crown with resin window. D2934 - Prefabricated esthetic coated stainless steel crown – primary tooth. D2940 - Protective restoration.	
The following services are not subject to a frequency limit. D2950 - Core buildup, including any pins. D2951 - Pin retention - per tooth, in addition to crown.	30%
The following services are limited to one every 60 months.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D2952 – Cast post and core in addition to crown. D2954 - Prefabricated post and core in addition to crown. D2962 – Labial veneer (porcelain laminate) – laboratory.	
The following service is not subject to a frequency limit. D2970 - Temporary crowns (fractured tooth).	30%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D3110 - Pulp cap - direct (excluding final restoration). D3120 - Pulp cap - indirect (excluding final restoration). D3220 - Therapeutic pulpotomy (excluding final restoration). D3221 - Pulpal debridement, primary and permanent teeth.	30%
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).	30%
The following services are limited to one per tooth per lifetime. D3310 - Anterior root canal (excluding final restoration). D3320 - Bicuspid root canal (excluding final restoration). D3330 - Molar root canal (excluding final restoration).	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - bicuspid. D3348 - Retreatment of previous root canal therapy - molar.	
The following service is not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification - interim medication replacement (limited to three treatments). *The following is limited to one per tooth per lifetime.* D3353 - Apexification/recalcification - final visit.	30%
The following services are limited to one per tooth per lifetime. D3410 - Apicoectomy/periradicular - anterior. D3421 - Apicoectomy/periradicular - bicuspid. D3425 - Apicoectomy/periradicular - molar. D3430 – Retrograde filling – per root.	30%
The following service is not subject to a frequency limit. D3426 – Apicoectomy/periradicular – each additional root.	30%
Periodontics (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one per 24 months per quadrant. D4210 - Gingivectomy or gingivoplasty - four or more teeth. D4211 - Gingivectomy or gingivoplasty - one to three teeth.	30%
The following service is limited to one per tooth per lifetime. D4249 - Clinical crown lengthening - hard tissue.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
The following service is limited to one every 60 months. D4260 - Osseous surgery. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. *The following services are not subject to a frequency limit.* D4263 - Bone replacement graft - first site in quadrant. D4264 – Bone replacement graft – each additional site in quadrant.	30%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure.	30%
The following service is not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth.	30%
The following services are limited to one per quadrant per lifetime. D4277 – Free soft tissue graft – first tooth. D4278 – Free soft tissue graft – additional teeth.	30%
The following services are not subject to a frequency limit. D4320 - Provision splinting - intracoronal. D4321 - Provision splinting - extracoronal.	30%
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.	30%
The following service is limited to a frequency to one per 12 months.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis.	
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance.	30%
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. 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). D5225 – Maxillary partial denture – flexible base. D5226 – Mandibular partial denture – flexible base. 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. *The following services are limited to one per lifetime.* D5130 – Immediate denture – maxillary. D5140 – Immediate denture – mandibular.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
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 - Repair broken complete denture base - mandibular. D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture. D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. 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.	30%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 24 months. D5730 - Reline complete maxillary denture (direct). D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct).	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect).	
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular). D5951 - Maxillofacial prosthetics (mandibular).	30%
Bridges (Fixed partial dentures) - (Subject to payment of the Annual Deductible.)	
The following services are limited to one every 60 months. D6205 – Pontic – indirect resin based composite. 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. D6245 - Pontic - porcelain/ceramic. D6250 - Pontic - resin with high noble metal. D6251 - Pontic - resin with base metal. D6252 - Pontic - resin with noble metal. D6545 – Retainer – cast metal for resin bonded fixed prosthesis. D6548 – Retainer – porcelain/ceramic for resin bonded fixed prosthesis.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
The following services are limited to one time every 60 months. D6710 – Crown – indirect resin based composite. D6721 – Crown – resin with base metal. 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. D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.	30%
The following services are not subject to a frequency limit. D6720 – Crown – resin with high noble metal. D6722 – Crown – resin with noble metal. D6740 - Retainer crown - porcelain/ceramic. D6794 – Crown – titanium.	30%
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond fixed partial denture.	30%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. D7111 – Extraction, coronal remnants – deciduous tooth. D7140 - Extraction, erupted tooth or exposed root.	30%
The following services are not subject to a frequency limit.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
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. D7260 Oroantral fistula closure. D7261 – Primary closure of a sinus perforation.	
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	30%
The following services are not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth. D7282 – Mobilization of erupted or malpositioned tooth to aid eruption. D7283 – Placement of device to facilitate eruption of impacted tooth. D7285 - Incisional biopsy of oral tissue – hard (bone, tooth). D7286 - Incisional biopsy of oral tissue – soft. D7288 – Brush biopsy – transepithelial sample collection.	30%
The following services are limited to one per quadrant per lifetime. D7310 - Alveoloplasty in conjunction with extractions - per quadrant.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - per quadrant. 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. D7450 - Removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm. D7451- Removal of odontogenic cyst or tumor - lesion greater than 1.25cm. D7471 - Removal of lateral exostosis (maxilla or mandible). D7472 – Removal of torus palatinus. D7473 – Removal of torus mandibularis. D7485 – Surgical reduction of osseous tuberosity.	30%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess. D7511 - Incision and drainage of abscess - intraoral soft tissue – complicated (includes drainage of multiple fascial spaces). *D7880 - Occlusal orthotic device, by report. (covered only for temporomandibular pain, dysfunction, or associated musculature)*	30%
The following service subjects to one per 1 lifetime per patient. D7960 - Frenulectomy. D7963 - Frenuloplasty.	30%
The following services are not subject to a frequency limit. *D7970 - Excision of hyperplastic tissue – per arch.*	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D7971 - Excision of pericoronal gingiva. *D7972 - Surgical reduction of fibrous tuberosity.*	
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.	30%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes. D9223 – Deep sedation/general anesthesia – each additional 15 minutes. D9230 – Inhalation of nitrous oxide/analgesia anxiolysis. D9243- Intravenous moderate (conscious) sedation/anesthesia - each 15 minutes. D9248 – Non-intravenous moderate (conscious) sedation.	30%
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	30%
The following services are not subject to a frequency limit, unless noted. D9420 – Hospital or ambulatory surgical center call, limited to a maximum of 3 per day. D9440 – Office visit – after regularly scheduled hours. D9610 – Therapeutic drug injection, by report; or D9612 – therapeutic drug injection – 2 or more medications, by report.	30%

SAMPLE

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 Co-insurance or Co-Payment.**
D9630 – Other drugs and/or medicaments, by report (not to be used for nitrous oxide or conscious sedation). D9910 – Application of desensitizing medicament. D9920 – Behavior management, by report. D9930 – Treatment of complications (pos-surgical) – unusual circumstances, by report. D9940 – Occlusal guard, by report. D9999 – Unspecified ambulatory procedure, by report (requires prior approval).	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only for Covered Persons with severe dysfunctional, handicapping malocclusion. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.	
The following services are not subject to a frequency limitation, except as noted, as long as benefits have been prior authorized. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8040 – Limited orthodontic treatment of adult dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8210 - Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting).	50%

SAMPLE

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 Co-insurance or Co-Payment.**
D8220 - Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting), limited to one per lifetime. D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8692 – Replacement of lost or broken retainer. D8999 – Unspecified orthodontic procedure, by report.	

SAMPLE

Schedule of Benefits: Pediatric Vision Care Services

Annual Deductible

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

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this Policy 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.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Schedule of Benefits

SAMPLE

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 per year.	None Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once per year.	
• Single Vision		30%
• Bifocal		30%
• Trifocal		30%
• Lenticular		30%
• ***Lens Extras***		
• Polycarbonate lenses	Once per year.	None Not subject to payment of the Annual Deductible.
• Standard scratch-resistant coating	Once per year.	None Not subject to payment of the Annual Deductible.
• Blended segment lenses	Once per year	80% of the billed charge
• Intermediate vision lenses	Once per year	80% of the billed charge

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Standard Progressives	Once per year	80% of the billed charge
• Premium Progressives	Once per year	80% of the billed charge
• Photochromic Glass	Once per year	80% of the billed charge
• Plastic Photosensitive	Once per year	80% of the billed charge
• Polarized	Once per year	80% of the billed charge
• Hi-index	Once per year	80% of the billed charge
• Standard anti-reflective coating	Once per year	80% of the billed charge
• Premium anti-reflective coating	Once per year	80% of the billed charge
• Ultra anti-reflective coating	Once per year	80% of the billed charge
• UV coating	Once per year	80% of the billed charge
Eyeglass Frames	Once per year.	
• Eyeglass frames with a retail cost up to $130.		30%
• Eyeglass frames with a retail cost of $130 - 160.		30%
• Eyeglass frames with a retail cost of $160 - 200.		30%
• Eyeglass frames with a retail cost of $200 - 250.		30%
• Eyeglass frames with a retail cost greater than $250.		30%
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	Once per year.	None Not subject to payment of the Annual Deductible.
• Covered Contact Lens Formulary	Limited to a 12 month supply.	30%

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Necessary Contact Lenses	Limited to a 12 month supply.	30%

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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 this Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements.

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 this Policy.

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

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

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

SAMPLE

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. Air emergency transportation by fixed wing or rotary wing when transportation to an acute care Hospital is Medically Necessary and ground or water transportation is not appropriate.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water 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.

In accordance with Virginia law, we will provide reimbursement for Benefits under this provision directly to the provider of such services when we have been presented with an assignment of benefits by the provider of the ambulance services.

Providers may not balance bill you for out-of-Network Emergency air ambulance services.

2. Autism Spectrum Disorder

Diagnosis of Autism Spectrum Disorder, including Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

Treatment of Autism Spectrum Disorder, which shall be identified in a treatment plan and includes the following Medically Necessary care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:

- Behavioral health treatment, which means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Pharmacy care, which means medications prescribed by a licensed physician and any health-related services Medically Necessary to determine the need or effectiveness of the medications.
- Psychiatric care provided by a licensed psychiatrist.
- Psychological care provided by a licensed psychologist.
- Therapeutic care, which means services provided by licensed or certified speech therapists, occupational therapists, or clinical social workers. Therapeutic care provided for the treatment of Autism Spectrum Disorder will not be subject to the visit limitations applicable to physical therapy, occupational therapy, and speech therapy.

SAMPLE

3. Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

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 interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI).*)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the *Office of Protection from Research Risks of the NCI*.

SAMPLE

    - 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 this Policy.

4. Dental Anesthesia and Services for Medical Treatments

General anesthesia and Hospital or Alternate Facility charges when the dentist and the Physician determine that such services are necessary for the safe and effective treatment of a dental condition. Benefits are provided only when a Covered Person meets at least one of the following conditions:

- Is a child under five years of age.
- Is severely disabled.
- Has a medical condition and requires admission to a Hospital or Alternate Facility and general anesthesia for dental treatment.

Covered Health Care Services must be provided under the direction of a Physician or dentist. Benefits are not available for the diagnosis or treatment of dental disease.

Covered Health Care Services include dental services, including x-rays, extractions, and anesthesia, to prepare the mouth for medical treatments such as radiation therapy to treat cancer and prepare for transplants.

SAMPLE

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

For Injuries occurring on or after the effective date of coverage, you must seek care within 12 months of the date the Injury was sustained or as soon after that as possible to be a Covered Health Care Service under the Policy or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits include dental appliances needed to treat an accidental injury to the teeth and the repair of existing dental appliances damaged as a result of accidental injury to the jaw, mouth or face as well as dental services. Benefits for treatment of accidental Injury are limited to Medically Necessary treatment.

Please note that injury caused by chewing or biting an object or substance placed in the Covered Person's mouth is not considered an accidental Injury, regardless of whether the Covered Person knew the object or substance was capable of causing such Injury if chewed or bitten. 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 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

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 implants, dentures or bridges.

6. 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, including treatment of corns, calluses, and care of toenails.

SAMPLE

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).

7. 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:

- Canes.
- Commode chairs.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Cochlear Implants.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Negative pressure wound therapy devices (wound vacuums).
- Oxygen equipment, oxygen, and oxygen concentrator.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Ventilator, or APAP, BPAP, or CPAP, and oral devices for documented obstructive sleep apnea.
- Walkers.
- Wheelchairs and batteries for powered wheelchairs.

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.* Benefits are also available for maintenance and supplies needed for use of the equipment, such as a battery for a powered wheelchair.

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 Policy.

8. Emergency Health Care Services - Outpatient

Services that are required to Stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Coverage shall be provided without the need for prior authorization and regardless of the final diagnosis rendered to the Covered Person.

Benefits include the Facility charge, supplies and all professional services required to Stabilize your condition and/or begin treatment. Benefits also include diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and Stabilize a patient with an Emergency medical condition. 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.*

9. Enteral Nutrition

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

SAMPLE

nutrients or formulas. Coverage also includes any medical equipment, supplies, and services that are required to administer the covered formula and enteral nutrition products. Examples of conditions include:

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

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.

10. Family Planning Services

Covered expenses include charges incurred by a covered person for:

- Diagnosis and treatment of any underlying cause of infertility.
- Diagnosis and treatment of any underlying cause of sexual dysfunction.
- Male sterilization.
- Reversal of a non-elective sterilization that was the result of a Sickness or Injury.
- 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.

11. 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. One example would be therapy by a licensed therapist for a child who is not walking or talking at the expected age. 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, including services to relieve pain; teach, keep, improve or restore function; prevent disability after illness, Injury, or loss of limb, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices; and treatment of lymphedema.

SAMPLE

- Occupational therapy, including services to teach, keep, improve or restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy, including services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment; therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age; and services to identify, assess, and treat speech, language, and swallowing disorders in children and adults.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

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

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

The following are not habilitative services:

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

SAMPLE

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.*

Benefits related to early intervention services as required by Virginia law include Benefits for speech and language therapy, occupational therapy, and physical therapy for Enrolled Dependent children from birth to age three who are certified by the *Department of Behavioral Health and Developmental Services* as eligible for services under *Part H of the Individuals with Disabilities Education Act* (*20 U.S.C. s1471 et seq.*).

Note: Habilitative services may include physical and occupational therapy, medical devices, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention benefit.

12. 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, home health therapist, 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 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.

Benefits include Durable Medical Equipment and medical supplies provided in the home health care setting. Examples of covered services include:

- Infusion Therapy.
- Diagnostic and social services.
- Nutritional guidance.
- Remote Patient Monitoring Services.

In accordance with Virginia law, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to any applicable annual maximums described in the *Schedule of Benefits* under *Home Health Care*.

Private Duty Nursing

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

SAMPLE

13. 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.

Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person’s primary caregiver a temporary break from caregiving responsibilities.

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

14. 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.*)
- A minimum Inpatient Stay of at least 48 hours following a radical or modified radical mastectomy and at least 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.
- A minimum Inpatient Stay of at least 23 hours for a laparoscopy-assisted vaginal hysterectomy and at least 48 hours for a vaginal hysterectomy.
- Inter-hospital transfer for newborn or mother without Prior Authorization, when Medically Necessary transfer is required due to a newborn or mother experiencing a life-threatening emergency condition.

SAMPLE

15. 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.
- Ultrasounds.
- Pathology services
- EEG and EKG services
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).
- Sleep testing. Benefits for any resulting Medically Necessary sleep treatment are available and will be provided based on where the Covered Care Health Service is provided (i.e., *Physician's office*

Services-Sickness and Injury, Durable Medical Equipment (DME),Orthotics and Supplies, etc.) as stated under each applicable category in this Section (*Section 1*).

Benefits include:

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

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

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

16. Manipulative Treatment

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services. Benefits include therapy to treat problems of the bones, joints, and back.

For Habilitative Manipulative Treatment, services must help you keep or improve skills and functioning for daily living. This includes services for people with disabilities in an inpatient or outpatient setting.

For Rehabilitative Manipulative Treatment, services must involve goals you can reach in a reasonable period of time. Benefits will end when progress toward the goal ends.

Benefits are limited as described in the Schedule of Benefits.

SAMPLE

17. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, MRS, CTA, SPECT scan, QCT Bone Densitometry, diagnostic CT colonography, nuclear cardiology, 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*.)

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

Mental Health Care and Substance-Related and Addictive Disorders Services including diagnosis and treatment of psychiatric conditions and 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. For Substance-Related and Addictive Disorders, eating disorders, and the like, inpatient services must be provided in a Hospital or treatment Facility that is licensed to provide a continuous, structured program of treatment and Rehabilitation, including 24-hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly and Rehabilitation, therapy, education, and recreational or social activities.
- Residential Treatment.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment for the treatment of Mental Health Care and Substance-Related and Addictive Disorders.
- 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 including psychological testing.
- Treatment and/or procedures including psychotherapy and group psychotherapy.
- Family therapy, including counseling with covered family members to assist with the patient's diagnosis. Benefits also include detoxification, and rehabilitation treatment. Including Hospital and inpatient professional charges in any hospital or Facility required by state law.
- Electroconvulsive therapy (ECT).
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Services at a Residential Treatment Facility.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care. As required by Virginia law, converting inpatient days to Partial Hospitalization/Day Treatment when Medically Necessary is at the option of the person or parent of a child or adolescent receiving treatment. In addition, services referred from a Psychiatrist, Psychologist, Neuropsychologist, LCSW, Clinical Nurse Specialist, Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC) or any agency licensed by the state to give these services are covered.

SAMPLE

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

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

19. 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).

Benefits are available for necessary medical supplies furnished by a Provider that are used once, such as syringes, needles, surgical dressings, splints, etc.

Ostomy Supplies are limited to the following:

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

Note: Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above (check the member specific benefit plan document for coverage of ostomy supplies).

20. Orthotics

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

Orthotic braces, customized or surgical grade boots, and splints (other than foot orthotics), 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.

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

21. Pharmaceutical Products - Outpatient

Pharmaceutical Products including injectable drugs, for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home. Coverage also includes injections administered at an authorized pharmacy. For information on blood products, refer to *Home Treatment of Hemophilia and Congenital Bleeding Disorders* under *Therapeutic Treatments - Outpatient*.

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

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

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product, unless the provider or its intermediary agrees in writing to accept reimbursement, including copayment, at the same rate as a Designated Dispensing Entity.

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

We may have certain programs in which you may receive an enhanced 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.

22. 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. Coverage includes Physician fees for second opinions.

23. 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 retail health clinic (walk-ins) or located in a Hospital.

Covered Health Care Services include:

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- A medical consultation with a Physician using the internet by webcam, chat, or voice. Online visits do not include reporting normal lab or test results; requesting an appointment; discussing billing, insurance, or payment issues; requesting a referral; benefit precertification; or your Physician's discussions with another Physician.
- Remote Patient Monitoring Services 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. Collection and analysis of patient physiologic data must be used to develop and manage the treatment plan for an acute or chronic illness or condition.
- Genetic Counseling.
- Allergy injections, allergy testing and treatment, and allergy serum.
- Infusion Therapy.
- Physician house calls as described under *Physician Fees for Surgical and Medical Services*.

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

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

Covered Health Care Services 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*.

SAMPLE

24. Pregnancy - Maternity Services

For a Covered Person or Dependent who becomes pregnant, Benefits for Pregnancy include all maternity-related medical services (including maternity-related checkups) for prenatal care, postnatal care, delivery (including delivery room and care and anesthesia services), routine nursery care during the mother's hospital stay, and any related complications, including complications for which hospitalization is necessary. Benefits are provided for Covered Health Care Services for delivery provided by a certified nurse midwife in a birthing center or home setting.

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 also include:

- Abortion when the mother's life is endangered or when the Pregnancy is the result of an alleged act of rape or incest.
- Folic acid supplements and expanded tobacco intervention and counseling for pregnant users.

- Circumcision of a covered male Dependent.

The following screenings for pregnant women are also covered:

- Anemia.
- Gestational diabetes.
- Hepatitis B.
- Rh incompatibility.
- Urinary tract or other infection.

The following fetal screenings are also covered:

- Genetic and/or chromosomal status of a fetus.
- Anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.

Some screenings are covered under *Preventive Care Services* and are exempt from cost sharing.

Benefits for postpartum care also include inpatient or home visits for the mother in accordance with the most current version of the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetrics and Gynecologists.

Postnatal care for the baby includes:

- Behavioral assessments and measurements.
- Screenings for blood pressure, hearing, hemoglobinopathies, hypothyroidism, and PKU.
- Gonorrhea prophylactic medication.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include breastfeeding/lactation counseling and 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.

SAMPLE

25. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.* Benefits also include:
  - Screenings for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, Type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use.
  - Counseling for alcohol misuse, nutrition, obesity, and sexually transmitted infection prevention.

- Smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription (refer to *Section 10: Outpatient Prescription Drugs*).
- Aspirin use to prevent cardiovascular disease (which is covered under the *Section 10: Outpatient Prescription Drugs*).

- 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*. Benefits include assessments for alcohol and drug use, behavioral, oral health risk; medical history; BMI measurements; screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision. Also includes counseling for obesity and STI. Benefits also include prescription fluoride chemoprevention supplements for children ages 0 - 16 (which is covered under the *Section 10: Outpatient Prescription Drugs*).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include:
  - Well woman visits.
  - Screenings for BRCA risk assessment and genetic testing, cervical cancer, domestic and interpersonal violence, HPV, HIV, sexually transmitted infections (STIs), and osteoporosis.
  - Counseling for breast cancer genetic testing (BRCA), breast cancer chemoprevention, domestic and interpersonal violence, and sexually transmitted infections (STIs).
  - Contraceptive methods and counseling. Coverage includes all 18 Food and Drug Administration approved contraceptive methods, including drugs, injectable, patches, rings, diaphragms, IUDs, implants, and sterilization procedures.
- Mammography including low-dose mammograms at certain age intervals. Benefits include a baseline mammogram for women 35 to 39 years of age, one such mammogram biennially to persons age 40 through 49, one such mammogram annually to persons age 50 and over.
- PSA testing and digital exam. Benefits include an annual diagnostic examination for the detection of prostate cancer and a prostate-specific antigen test for each person who is at least 50 years old and asymptomatic, or who is at least 40 years old with a family history of prostate cancer or another prostate cancer risk factor. Coverage for the diagnostic examination will be provided in accordance with guidelines established by the *American Cancer Society*. Services for prostate-specific antigen testing will be covered at least once in any 12 month period.

SAMPLE

26. Prosthetic Devices

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

- Artificial arms, legs, feet and hands, and components Medically Necessary for daily living.
- 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.
- Composite facial prosthesis.

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 Policy.

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

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

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

27. 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 in both an outpatient and inpatient setting. Coverage includes procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.

Cleft Lip and Cleft Palate Treatment

Coverage for inpatient and outpatient dental, oral surgical, and orthodontic services for the treatment of a child in connection with cleft lip, cleft palate, or ectodermal dysplasia. Services must be provided under the direction of a Physician. Benefits also include dental services and dental appliances to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

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.

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

SAMPLE

28. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy, including services to relieve pain; teach, keep, improve or restore function; prevent disability after illness, Injury, or loss of limb, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices; and treatment of lymphedema.
- Occupational therapy, including services to teach, keep, improve or restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy, including services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment; therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age; and services to identify, assess, and treat speech, language, and swallowing disorders in children and adults.

- Pulmonary Rehabilitation Therapy, including outpatient short-term respiratory care following an illness or Injury.
- Cardiac rehabilitation therapy, including medical evaluation, training, supervised exercise, and psychosocial support following a cardiac event. Services will not be provided for home programs (other than home health care services), on-going conditioning, and maintenance care.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Physical, occupational, and speech therapy for Rehabilitation sets goals that are attainable in a reasonable period of time.

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. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

29. 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*.

30. 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:

SAMPLE

- Supplies and non-Physician services received during the Inpatient Stay, including Medically Necessary drugs and biological drugs/products.
- Room and board in a Semi-private Room (a room with two or more beds). Benefits are available for a private room only when Medically Necessary.
- 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).

31. Surgery - Outpatient

Surgery and related services , including pre-operative and post-operative care, 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 coverage for certain invasive procedures. Examples of invasive procedures include:

- Treatment of fractures and dislocation.
- Angiogram/Arteriogram.
- Amniocentesis.
- Collection of cerebral spinal fluid.

Benefits include:

- The Facility charge and the charge for supplies and equipment, such as hypodermic needles, syringes, surgical dressings, splints, etc.
- Blood and blood products.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

Benefits also include maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy related to tooth extraction; orthognathic surgery required to attain functional capacity; surgical services on the hard or soft tissue of the mouth for purposes not related to treat or help teeth and supporting structures; removal of tumors, treatment of non-dental lesions; biopsies; incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

SAMPLE

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 Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

32. Telehealth

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

Telehealth/Telemedicine - live, interactive online visits by webcam, chat, or voice of a Physician-patient encounter from one site to another using telecommunications technology, including Remote Patient Monitoring Services. The site may be a CMS defined originating Facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider. Benefits for Remote Patient Monitoring Services are described under *Physician Office Services - Sickness and Injury*.

33. 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).

SAMPLE

34. 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, including home intermittent peritoneal dialysis, home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis). Home equipment, supplies, and training for chronic (end-stage) renal disease are also covered Benefits.
- Intravenous Chemotherapy or other intravenous Infusion Therapy.
- Radiation oncology, including but not limited to, treatment by x-ray, radium, or radioactive isotopes. Also includes materials and supplies, administration, treatment planning, and other covered services.

- Blood and the administration of blood products and blood infusion equipment required for the outpatient or home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. A home treatment program must be under the supervision of a state-approved hemophilia treatment center. "State-approved hemophilia treatment center" means a Hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.
- Outpatient self-management training and education for the treatment of lymphedema and complex decongestive therapy in connection with lymphedema.
- The Facility charge and the charge for related supplies and equipment including those related to lymphedema.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

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.

In accordance with Virginia law, cost-sharing (Co-payments, Co-insurance or Deductible amounts) for orally administered chemotherapy drugs and cancer chemotherapy drugs shall not be greater than cost-sharing for such drugs administered intravenously or by injection.

35. Transplantation Services

Organ and stem cell/bone marrow transplants and infusions, 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 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 this Policy, limited to donor:
- Identification.
- Evaluation.

SAMPLE

- Organ removal.
- Direct follow-up care.

Benefits include Medically Necessary transfusions, acquisition procedures (including benefits provided to the donor for the costs of organ removal from a living donor), mobilization, harvest and storage, and preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

Reimbursement for reasonable and necessary transportation and lodging costs for the Covered Person receiving care and a companion are covered, or for two companions if the Covered Person receiving care is a minor.

Reimbursement for reasonable and necessary transportation and lodging costs for the donor are covered when the recipient and donor are covered under the same Policy. Benefits may be limited if only the recipient is covered under the Policy.

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

36. 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*.

37. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions and remote patient monitoring. 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. A Designated Virtual Network Provider may be a local provider, who offers health care services to a patient population within a fixed or defined geography, or a national care provider, who offers health care services to a patient population within the entirety of the United States, including United States territories.

SAMPLE

38. Vision Correction After Surgery or Accident

Benefits for prescription eyeglasses or contact lenses when required as a result of surgery or for the treatment of an accidental Injury.

Benefits are limited to the purchase and fitting of eyeglasses or contact lenses when:

- Prescribed to replace the human lens lost due to surgery or Injury.

Benefits are limited to the purchase and fitting of eyeglasses when:

- "Pinhole" eyeglasses are prescribed for use after surgery for a detached retina.

Benefits are limited to the purchase and fitting of contact lenses when:

- Contact lenses are prescribed in place of surgery in the following situations:
  - Contact lenses are used for the treatment of infantile glaucoma;
  - Corneal or scleral lenses are prescribed in connection with keratoconus;
  - Scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate;
  - Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Benefits include:

- The cost of materials and fitting;
- Exams;
- Replacements of prescription eyeglasses or contact lenses when the prescription changes and such change is related to either: 1.) the medical condition that necessitated surgery; or 2.) the accidental Injury that necessitated the original prescription.

Benefits are provided only as described above. Examples of excluded items include, but are not limited to, sunglasses or safety glasses and accompanying frames of any type; any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power; any lost or broken lenses or frames; any blended lenses (no line), oversize lenses, polycarbonate lenses, progressive multifocal lenses, photochromatic lenses, "Transitions" lenses, tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses; or any frame in which the manufacturer has imposed a no discount policy.

SAMPLE

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 this *Policy*.

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. 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

The following exclusions do not apply to Benefits for pediatric dental care as described in *Section 11: Pediatric Dental Care Services*.

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

SAMPLE

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.
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. This exclusion does not apply to treatment of ectodermal dysplasia or Congenital Anomalies that cause functional impairment as described in *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

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.

SAMPLE

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.

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.
5. Growth hormone therapy.
6. 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.
7. 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.
8. 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.
9. 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.
10. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
11. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

SAMPLE

E. Experimental or Investigational Services

Experimental or Investigational Services and all services related to Experimental or Investigational Services are excluded. The fact that an Experimental or Investigational 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 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 for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

2. Nail trimming, cutting, or debriding. 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*.
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.

SAMPLE

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings. This exclusion does not apply to supplies for which Benefits are described in *Necessary Medical Supplies* in *Section 1: Covered Health Care Services*.
   - Items routinely found in the home.
   - 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.

H. 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 nutritional counseling described under *Diabetes Services, Hospice Care or Physician Office Services - Sickness and Injury* in *Section 1: Covered Health Care Services* and 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 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.
4. 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.
5. 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.

I. 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, except as covered under *Durable Medical Equipment (DME)*.
   - 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.

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- 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.

J. 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.
   - Lip augmentation.
   - Lip reduction.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
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.

SAMPLE

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.*

K. 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.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. 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.

L. 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

SAMPLE

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 or Emergency Health Care Services.

M. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
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 or as a result of incest or rape.
9. Fetal reduction surgery.

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N. 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. 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.

3. Health care services during active military duty.

O. 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 this Policy.)

3. Health care services for transplants involving animal organs.

4. Transplant services not received from a Designated Provider.

P. Travel

1. Health care services provided in a foreign country.

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.* Travel costs: mileage, lodging, meals, and other Covered Person-related travel costs except as described in the medical Schedule of Benefits.

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Q. 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.

5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.

6. Rest cures.

7. Services of personal care aides.

8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

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

10. Private Duty Nursing, except when required on a home basis as described in this Policy. Private Duty Nursing services in an Inpatient setting remain excluded.

R. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to benefits for glasses or contact lenses as described under *Vision Correction After Surgery or Accident* in *Section 1: Covered Health Care Services* and in *Section 12: Pediatric Vision Care Services*.
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to benefits for routine vision exams as described in *Section 12: Pediatric Vision Care Services*.
3. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

S. All Other Exclusions

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.
12. 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:

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- 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 Policy under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Policy* under *Section 2: Exclusions and Limitations*.

13. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under this *Policy* when:
    - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
    - Required to get or maintain a license of any type.
14. 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.
15. Health care services received after the date your coverage under this Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under this Policy ended.
16. 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 this Policy.
17. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
18. 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 member 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.
19. Autopsy.
20. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
21. 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

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disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

22. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).
23. Blood or tissue typing for paternity testing are not a covered service.
24. Specimen Provenance testing are not a covered service.
25. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the benefit plan.
26. For telephone consultations (except telehealth) or for failure to keep a scheduled appointment.
27. For stand-by availability of a medical practitioner when no treatment is rendered.
28. For services or supplies that are provided prior to the effective date or after the termination date of this Policy.

SAMPLE

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 Virginia Insurance Exchange Marketplace. 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 this Policy.

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

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

Who Is Eligible for Coverage?

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The Virginia Insurance Exchange 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 Virginia Insurance Exchange Marketplace. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

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

Dependent

Dependent generally refers to the Policyholder'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 Policy.

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 Virginia Insurance Exchange Marketplace.

Coverage begins on the date determined by the Virginia Insurance Exchange Marketplace and identified in this Policy 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 Virginia Insurance Exchange Marketplace.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Virginia Insurance Exchange Marketplace.

The Policyholder must notify Virginia Insurance Exchange Marketplace of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow Virginia Insurance Exchange Marketplace rules. Additional Premium may also be required, and it will be calculated from the date determined by Virginia Insurance Exchange Marketplace.

NOTE. Subject to a determination of Virginia Insurance Exchange 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

SAMPLE

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

(Note that Benefits for Outpatient Prescription Drugs, Adult Vision Care Services, Adult Dental Care Services, Pediatric Vision Care Services, and Pediatric Dental Care Services, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.)

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 Virginia Insurance Exchange Marketplace of your new residence. Your Premium will be based on your new residence beginning on the date determined by Virginia Insurance Exchange Marketplace. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy 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 this Policy 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 Policyholder 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 this Policy 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 pro rata Premium due from you by the end of the grace period.

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 Policyholder at least 31 days prior to the effective date of the change.

SAMPLE

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

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

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

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

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

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

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

This Policy 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 Policy 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.

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What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

  - The date determined by the Virginia Insurance Exchange Marketplace that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy 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 this Policy 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 Policyholder or an Enrolled Dependent, as determined by the Virginia Insurance Exchange Marketplace. Please refer to *Section 8: Defined Terms* for definitions of the terms “Eligible Person,” “Policyholder,” "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

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

We will provide advance notice of when coverage ends, except for terminations due to non-payment of premiums or a change in eligibility status.

Other Events Ending Your Coverage

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

- **Failure to Pay**

  You fail to pay the required Premium. We will provide at least 31 days advance written notice if coverage ends due to non-payment of premiums.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  We will provide at least 30 days advance required notice to the Policyholder 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. You have the right to a refund of all premiums paid less any claims paid beyond the date on which coverage ends.

  The 30 days advance notice will include:

  - ♦ Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
  - ♦ An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of material fact;
  - ♦ Notice that you or your authorized representative, prior to the date the advance notice ends of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
  - ♦ A description of our internal appeal process for rescissions, including any time limits applicable to those procedures; and

  The date when the advance notice ends and the date back to which the coverage will be rescinded.

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- **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 this Policy. 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 Policyholder 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 this Policy.

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

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

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

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Virginia Insurance Exchange Marketplace.

SAMPLE

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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 Policyholder'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).

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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

Time for Payment of Claim

Benefits will be paid within 60 days after receipt of all of the required information listed above.

Assignment of Benefits

When Benefits are assigned to a provider of covered ambulance services, we will pay the provider directly. When Benefits are assigned to a provider of Covered Health Care Services who is a dentist or oral surgeon, we will pay the provider directly.

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

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

It is your responsibility to apply any payment received from us related to Services received from an Out-of-Network provider to the claim from the Out-of-Network provider.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate.

SAMPLE

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

Appeals & Grievances Department

PO Box 6111

Mail Stop CA-0197

Cypress, CA 90630

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

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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.

Concurrent review requests are considered pre-service requests. "Concurrent review" means utilization review conducted during your stay or course of treatment in:

- A Facility;
- The office of a health care professional; or
- Other inpatient or outpatient health care setting.

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 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

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

Appeal Determinations

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

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

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

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure including our determination that a treatment, device, or pharmacological regimen is not covered because it is an Experimental or Investigational Service.

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

Concurrent Review Requests

Reduction or termination of approved treatment to be provided over time or over a number of treatments constitutes an adverse benefit determination. In such cases, we must notify you sufficiently in advance to allow you to file an internal appeal and obtain a determination before benefits are reduced or terminated.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

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

- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from you or your Physician to make a decision, we will notify you or your Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete our review. You or your Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. We will notify you and your Physician of the decision not later than 48 hours after the earlier of 1) our receipt of the specified information or 2) the end of the period afforded to provide the requested information. The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

SAMPLE

- For all other non-urgent review requests, see Pre-service Requests for Benefits and Post-service Claim Appeals above.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you or your Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete our review. You or your Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. We will notify you and your Physician of the decision not later than 48 hours after the earlier of 1) our receipt of the specified information or 2) the end of the period afforded to provide the requested information.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

If you have requested an urgent internal appeal, you may also, at the same time, request an expedited external review when the appeal involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function. The process for submitting an expedited external appeal is described below under Expedited External Review.

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

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Exhaustion of Internal Appeal Process

You must exhaust the internal appeal process before submitting a request for external review as described below under *Virginia External Review Program*. The internal appeal process is considered exhausted when:

- You have completed the standard internal appeals process as described above under Pre-service *Requests for Benefits and Post-service Claim Appeals*.
- You did not receive a decision from us within the required time frame concerning a standard internal appeal.
- You have requested an urgent internal appeal as described under Urgent Appeals that Require Immediate Action, in which case you may also make a written or verbal request for an expedited external review (see *Expedited External Review* below).
- We waived the requirement to exhaust the internal appeal process.
- We violated Virginia internal appeal requirements, except where such violation is a "de minimus" violation, which means the violation does not cause, and is not likely to cause, prejudice or harm to you so long as we demonstrate that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange between you and us. You may:
  - Request written explanation of the violation from us, and we will provide written explanation within 10 days of receipt of your request.

- Request *IRO* review to determine if we have violated Virginia internal appeal requirements. The *IRO* will provide a written response to you, us and the commission within 10 days of receipt of your request. If rejected, within 5 days we must notify you of your right to resubmit and pursue an internal appeal.

Office of the Managed Care Ombudsman/Office of Licensure and Certification

If you have any questions regarding the appeals processes outlined above or other grievances concerning health care coverage issues that have not been satisfactorily addressed by us, you may contact the *Office of the Managed Care Ombudsman* for assistance at any time as follows:

Office of the Managed Care Ombudsman

P.O. Box 1157

Richmond, VA 23218

Phone number: (877) 310-6560

Fax number: (804) 371-9944

E-mail: Ombudsman@scc.virginia.gov

In addition, if you have any questions regarding an appeal or grievance concerning provider quality of care issues that have not been satisfactorily addressed by the provider or your plan, you may contact the *Office of Licensure and Certification* for assistance at any time as follows:

Department of Health Professions

Virginia Department of Health

9960 Maryland Drive, Suite 300

Henrico, Virginia 23233-1463

Telephone: (800) 533-1560 or (804) 367-4691

Fax: (804) 527-4424

E-mail: enfcomplaints@dhp.virginia.gov

SAMPLE

Virginia External Review Program

If, after exhausting your internal appeals, as described above under *Exhaustion of Internal Appeal Process*, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination. This process is administered by the *Virginia Bureau of Insurance*. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

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 service, treatment or procedure does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness).
- The exclusions for Experimental or Investigational Services.
- As otherwise required by applicable law.
- An adverse determination relates to the treatment of a cancer.

If you wish to appeal our final decision as described above, you or your representative may file a request for a standard external review in writing with the *Virginia Bureau of Insurance*. If, in urgent situations as detailed below, you wish to file a request for an expedited external review, you or your representative may

do so by sending a written request to the *Virginia Bureau of Insurance's* address. We will provide to you, at the time a final adverse decision is reached, a copy of the *Virginia Bureau of Insurance's* external review request form, which contains the address and information for requesting an external review.

An external review will be performed by an *Independent Review Organization (IRO*). There are two types of external reviews available:

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

A request for a standard external review must be made within 120 days after the FINAL adverse determination is received and must include a general release for all medical records pertinent to the external review. An expedited external review in urgent situations may be requested as detailed below under Expedited External Review. If one of the following circumstances applies, you may request an external review prior to exhausting the internal appeal process:

- You did not receive a decision from us within the required time frame concerning a standard internal appeal.
- We waived the requirement to exhaust the internal appeal process.
- In the case of an expedited external review request, for the reasons described below under *Expedited External Review*.

If you have questions about the external review process, you may contact the *Virginia Bureau of Insurance* directly at:

Bureau of Insurance - External Review

P.O. Box 1157

Richmond, VA 23218

Telephone: (877) 310-6560

Fax: (804) 371-9944

E-mail: OLC-Complaints@vdh.virginia.gov

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Standard External Review

A standard external review includes of all of the following:

- A preliminary review by us of the request meets the eligibility requirements for external review.
- A referral of the request by us to the *Virginia Bureau of Insurance*.
- Assignment of an *IRO* by the *Virginia Bureau of Insurance*.
- A decision by the *IRO*.
- An adverse determination relates to the treatment of a cancer.

Within five business days following receipt of your request from the *Virginia Bureau of Insurance*, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy 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 the preliminary review, we will issue a notification in writing to you, your representative, if applicable, and the Virginia Bureau of Insurance. If the request is eligible for external review, the

Virginia Bureau of Insurance will assign an *IRO* to conduct such review. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

The *Virginia Bureau of Insurance* will notify you in writing of the request's eligibility and acceptance for external review and provide the name of the assigned *IRO*. You may submit in writing to the IRO within five business days after the date you receive the IRO's external review additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after five 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, your representative and us, and it will include the clinical basis for the determination.

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

The written ruling of the *IRO* is final and binding on both you and us.

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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, and in some instances you may file an expedited external review before completing the internal appeals process. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

You may make a written request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an urgent internal appeal.
- An adverse determination relates to the treatment of a cancer.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request from the *Virginia Bureau of Insurance*, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy 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, the *Virginia Bureau of Insurance* will assign an *IRO* in the same manner utilized to assign standard external reviews to *IROs*. We will provide all required documents and information considered 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 expeditious method. 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 except that, for an expedited external review concerning Experimental or Investigational Services, the *IRO* will provide notice of the final external review decision within 48 hours after the date it receives an opinion from all assigned clinical reviewers, who will have up to five days to provide an opinion to the *IRO*. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to us.

The written ruling of the IRO is final and binding on both you and us.

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.

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Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We administer this Policy 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 Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

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

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

What Is Our Relationship with Providers?

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, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable. You will not be responsible for an amount that exceeds the Allowed Amount if Covered Health Care Services are received from a Network provider, if Emergency Covered Health Care Services are received from an out-of-Network provider, or if surgery, anesthesiology, pathology, radiology, hospitalist or laboratory Covered Health Care Services are received at a Network Facility on a non-Emergency basis.
- 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.

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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 Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in 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-affiliated 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.

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

- Interpret Benefits under this Policy.

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

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

However, any exercise of such authority, whether by us or such other persons or entities, is subject to your rights of appeal and external review as described in *Section 6: Questions, Complaints and Appeals*.

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.

Any exercise of such discretion, whether by us or such other persons or entities, is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

Amendments to this Policy

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end this Policy. For any change that amounts to a Benefit reduction, we will provide written notice of a benefit reduction sixty (60) days before it becomes effective. We will notify you of the change thirty (30) days prior to the effective date of the benefit reduction. Any exercise of such discretion is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder'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 this Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

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

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

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

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

Is Workers' Compensation Affected?

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

Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Note: the coordination with Medicare only applies to those eligible for Medicare due to age and does not apply to members who are eligible for Medicare due to End Stage Renal Disease (ESRD).

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after proof of loss has been filed in accordance with the Policy. After completing that process, if you want to bring a legal

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action against us you must do so within three years of the date that proof of loss was required to be filed or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to such person's beneficiary or personal representative. All statements made by the Covered Persons shall be deemed representations and not warranties. A copy of any application shall be attached to the Policy when issued.

A provision that the Policy and any amendments to it constitutes the entire contractual agreement between the parties involved and that no portion of the charter, bylaws, or other document of the health maintenance organization shall constitute part of the Policy unless it is set forth in full in the Policy.

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Section 8: Defined Terms

Air Ambulance - medical transport by helicopter or airplane.

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

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

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

Reimbursement levels for Emergency Health Care Services and non-emergency services provided to at a Network Facility by an out-of-Network provider will be based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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.

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 the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

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

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities. Autism spectrum disorder means any pervasive developmental disorder, including:

- autistic disorder,
- Asperger's Syndrome,
- Rett syndrome, (iv) childhood disintegrative disorder, or
- Pervasive Developmental Disorder -- Not Otherwise Specified, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.

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

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

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

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.

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

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

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

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

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

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

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

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

Covered Person - the Policyholder or a Dependent, but this term applies only while the person is enrolled under this Policy. We use "you" and "your" in this Policy 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 Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.

SAMPLE

- A child placed for adoption or placement in foster care.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse including a foster child.

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.*

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

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

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

Designated Provider – a Network 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 as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category.

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.

SAMPLE

Designated Virtual Network Provider - a Network 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.

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.

Early Intervention Services - speech and language therapy, occupational therapy, physical therapy, and assistive technology and devices. Early intervention services for the population certified by the

Department are those services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment.

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

Emergency - Regardless of the final diagnosis rendered to a Covered Person, 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 physical or mental health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Danger of serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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, 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 Policy 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 the provider or Facility, as described above, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation.

SAMPLE

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

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

- 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.

Facility - an institution providing health care related services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

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.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

SAMPLE

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.

Hospice Care - an integrated, structured, multi-disciplinary program of palliative care for covered members 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.

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

- Nursing, durable medical equipment, and drugs delivered and administered by a health care provider as part of a Physician's visit, home care visit, or at an outpatient Facility.
- Drug infusion therapy, blood products, and injectables that are not self-administered.
- Total Parenteral Nutrition (TPN) and enteral nutrition therapy.
- Antibiotic therapy.
- Chemotherapy.
- Pain care.

Infusion of special medical formulas as the primary source of nutrition for persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies.

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.

SAMPLE

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

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 treatment over a period of three or more continuous hours per day 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.

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.

SAMPLE

Medically Necessary - health care services, that are all of the following as determined by us or our designee subject to the appeal rights described in *Section 6: Questions, Complaints and Appeals*.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, 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), 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 1394, et seq. and as later amended.

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

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

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

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.

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.

SAMPLE

- 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-Pocket Limit - the maximum amount you or someone on your behalf pays, to the extent allowed by law, 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 that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence, who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Treatment shall be provided over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

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 Policy.

SAMPLE

Policy - the entire agreement that includes all of the following:

- This Policy
- *Schedule of Benefits*.
- Policyholder *Application*.
- Riders.
- Amendments.

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

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Pregnancy - includes all of the following:

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

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

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.

Pulmonary Rehabilitation Therapy -- Introduction into the lungs of dry or moist gases, nonpressurized inhalation; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho pulmonary drainage and breathing exercises.

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

Recognized Amount - the amount which Co-payment, Co-Insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers. 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 Network Facilities for Surgical or Ancillary Services.

   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.

SAMPLE

For Emergency Health Care Services provided to a Covered Person by an out-of-Network provider and for non-emergency services provided to a Covered Person at a Network Facility by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or the commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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.

Remote Patient Monitoring Services - the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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 Policy. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Secretary - 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. A description of the Service Area is provided to you at the time of enrollment. 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 this Policy 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.

SAMPLE

- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.

Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

Stabilize - means, with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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

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.

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

- Related to any professional services, including surgery, anesthesiology, pathology, radiology and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists; and
- Diagnostic services, including radiology and laboratory services.

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

Telehealth/Telemedicine - live, interactive online visits by webcam, chat, or voice of a Physician-patient encounter from one site to another using telecommunications technology, including remote patient monitoring services. The site may be a *CMS* defined originating Facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

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.

SAMPLE

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.

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.

SAMPLE

Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: liability insurance contracts or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be coordinated with 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.

SAMPLE

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 coordinate the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

SAMPLE

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

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

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

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

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

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

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

      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

SAMPLE

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

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

SAMPLE

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

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

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

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

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

If you have not enrolled in Medicare:

Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies;

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

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

Note: the coordination with Medicare only applies to those eligible for Medicare due to age and does not apply to members who are eligible for Medicare due to End Stage Renal Disease (ESRD).

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.

SAMPLE

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.

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 coordinated benefits.

SAMPLE

Section 10: Outpatient Prescription Drugs

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 PDL, we will notify you no less than 30 days prior to the change. 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 Policy.

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 the Policy in *Section 5: How to File a Claim*. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

OptumRx Claims Department,

SAMPLE

PO Box 650540,

Dallas, TX 75265-0540

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may not have coverage.

Smart Fill Program - Split Fill

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

When Do We Limit Selection of Pharmacies?

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

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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-affiliated 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. In addition, you may receive coupons directly from manufacturers or other third parties. If the coupon is accepted, it will be applied to your Co-payment, Co-insurance, Deductible, Out-of-Pocket Limit for your Prescription Drug Product to the extent allowed by law.

Special Programs

We may have some programs in which you may receive an enhanced 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.

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 Policy. Your access to these programs is provided by us separately or independently from the Policy, 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 Co-insurance 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, Co-insurance 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.

Benefits are provided for a Prescription Drug Product not approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed provided that:

- The drug has been approved by the FDA for at least one indication; and
- The drug has been recognized as safe and effective for the treatment of the specific condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits are also provided for any Prescription Drug Product approved by the Food and Drug Administration (FDA) for use in the treatment of cancer even if the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any the standard reference compendia. "Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier. "Standard reference compendia" means the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, or The United States Pharmacopoeia Dispensing Information.

However, Benefits for any Prescription Drug Product approved by the Federal Drug Administration

(FDA) for use in the treatment of cancer pain are covered even if the supply limit is exceeded if the prescription in excess of the supply limit has been prescribed for a patient with intractable cancer pain.

SAMPLE

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If, however, a non-Designated Pharmacy or its intermediary has notified us or our intermediary that it agrees to accept reimbursement at the rate applicable to a Designated Pharmacy as payment in full, it may be possible to receive Benefits on the same basis and at the same cost-share as you would from a Designated Pharmacy. The non-Designated Pharmacy or its intermediary must, if requested to do so in writing by us or our intermediary, execute and deliver to us or our intermediary, within 30 days of the pharmacy's receipt of our request, the Network provider agreement, which we require of all Designated Pharmacies. Any non-Designated Pharmacy or its intermediary which fails to timely execute and deliver such agreement will continue to be treated as a non-Designated Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

Depending upon your plan design, this *Outpatient Prescription Drug Policy* 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 and 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 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.

Exclusions

Exclusions from coverage listed in the Policy *also* apply to this Policy. 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 or its intermediary. If, however, an Out-of-Network Pharmacy or its intermediary has notified us that it agrees to accept reimbursement at the rate applicable to a Network Pharmacy as payment in full, it may be possible to receive Benefits on the same basis and at the same cost-share as you would from a Network Pharmacy. The Out-of-Network Pharmacy or its intermediary must, if requested to do so in writing by us, execute and deliver to us, within 30 days of the pharmacy's receipt of our request, the participating provider agreement, which we require of all Network Pharmacies. Any Out-of-Network Pharmacy or its intermediary which fails to timely execute and deliver such agreement will continue to be treated as an Out-of-Network Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.
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.

SAMPLE

6. Experimental or Investigational Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental or investigational.

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. This exclusion does not apply to Medicaid.

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 provided in your Policy. 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 provided in your Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.

13. Certain unit dose packaging or repackagers of Prescription Drug Products.

14. Medications used for cosmetic purposes.

15. Prescription Drug Products, including new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.

16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Drug Products not included on any Tier of the Prescription Drug List. The IEPMC does not exclude coverage for any Prescription Drug Product solely on the basis of the length of time since the drug obtained FDA approval.

18. 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.)

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to monthly. 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 drugs used for tobacco cessation.

20. Certain new dosage forms until the date they are reviewed and placed on a tier by our IEPMC.

SAMPLE

21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
23. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products that have not been prescribed by a Specialist.
26. Dental products, including but not limited to prescription fluoride topicals. This does not include prescription fluoride supplements for children 0-16.
27. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product, unless Medically Necessary.

    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 may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
28. Diagnostic kits and products.
29. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
30. 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.
31. Prescription Drug Products when prescribed to treat erectile dysfunction or sexual dysfunction.

SAMPLE

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.

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

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

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

Medical Formulas - special medical formulas which are the primary source of nutrition for the Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

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, Co-insurance 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.

SAMPLE

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 - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/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 Policy, this definition includes:

- Inhalers (with spacers).

- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Self-administered injectable drugs.
- Flu shots and their administration.
- 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.

Tier - the applicable prescription drug copayment amount, the prescription drug deductible amount, and the prescription drug coinsurance percentage, if any, are determined by the Tier to which the prescription drug is assigned. Our Individual Exchange Pharmacy Management Committee (*"IEPMC"*) assigns each prescription drug to a Tier. A Covered Person can determine the Tier status for a prescription drug by accessing his or her prescription benefits via our website at www.myuhc.com/exchange or by calling the telephone number on your identification card. Non-formulary drugs, which are approved for use as Medically Necessary subsequent to clinical review and authorization by the plan, will be subject to the Tier 4 cost share unless they are considered a Specialty Prescription Drug Product, in which case the Tier 5 cost share will apply.

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.

SAMPLE

Your Right to Request an Exclusion Exception

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

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits*.

You may obtain coverage without additional cost sharing beyond that which is required of formulary Prescription Drug Products for a non-formulary drug if we determine, after consultation with the prescribing Physician, that the formulary Prescription Drug Product is inappropriate for your condition. You may obtain coverage without additional cost sharing beyond that which is required of formulary Prescription Drug Products if:

- You have been taking or using the non-formulary Prescription Drug Product for at least six months prior to its exclusion from the formulary; and

The prescribing Physician determines that either the formulary Prescription Drug Product is inappropriate therapy for your condition or that changing drug therapy presents a significant health risk.

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.

SAMPLE

Section 11: Pediatric Dental Care Services

This section provides benefits for Covered Pediatric 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 the Policy in *Section 8: Defined Terms* or in this section in *Defined Terms for Pediatric Dental Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you' and "your" we are referring to people who are Covered Person, as the term in defined in the Policy 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.

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What Are Covered Dental Care Services?

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

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

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

Benefits 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 Policy.

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.

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Pediatric Dental Exclusions

Except as may be specifically provided in this Policy under *Section 11: Pediatric Dental Care Services*, Benefits are not provided under this Policy for the following:

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this Policy in *Section 11: 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 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 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. Except for Occlusal orthotic device for TMJ, which covered only for temporomandibular pain dysfunction or assoc. musculature.
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 Policy to the Policy.
17. Dental Care Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Policy ends.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.

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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 Policy.

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Defined Terms for Pediatric Dental Care Services

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

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Policy 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 Policy.

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 Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Care Services and supplies under this Policy 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*.

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(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 Policy. The definition of Necessary used in this Policy relates only to Benefits under this Policy and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Section 12: Pediatric Vision Care Services

This section provides Benefits for Pediatric 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 the Policy in *Section 8: Defined Terms* or in this section in *Defined Terms for Pediatric Vision Care Services*.

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

Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from an Optimum Choice, Inc. Vision Network Vision Care Provider. To find an Optimum Choice, Inc. Vision Network Vision Care Provider, you may call the provider locator service at (877) 265-9199. You may also access a listing of Optimum Choice, Inc. 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 an Optimum Choice, Inc. 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.

What Are the Benefit Descriptions?

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.

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- 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.

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Pediatric Vision Exclusions

Except as may be specifically provided in this Policy under *Section 12: Pediatric Vision Care Services*, Benefits are not provided under this Policy 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 Policy.
2. Vision Care Services received from a non-Optimum Choice, Inc. 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 12: 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 the Policy.

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the Policy:

Covered Contact Lens Formulary - a selection of available contact lenses that may be obtained from an Optimum Choice, Inc. Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Optimum Choice, Inc. Vision Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

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

Vision Care Service - any service or item listed in this Policy in *Section 12: Pediatric Vision Care Services.*

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Section 13: Adult Dental Care Services

Benefits for Covered Dental Care Services, as described below, for Covered Persons age 19 and older. Benefits under this Section will end on the last day of the calendar year.

What Are Defined Terms?

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

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

Accessing Adult 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 Care Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Care 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.

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 Care Service under this section.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Care 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 Care Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively

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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.

Benefits for Adult 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 this section, under the heading *Adult Dental Exclusions*.

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.

Dental Out-of-Pocket Limit - any amount you pay in Coinsurance for adult Dental Care Services under this section does not apply to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

The Maximum Benefit is $1,000 per Covered Person per calendar year.

The Maximum Benefit applies to: ALL COVERED DENTAL CARE SERVICES.

All Dental Care Services and procedures follow the criteria specified in the *Current Dental Terminology (CDT)* listing as defined by the *American Dental Association*.

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Benefits

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
CLASS I **DIAGNOSTIC SERVICES ORAL EVALUATION(DIAGNOSTIC) X-RAYS- OTHER X-RAYS- BITEWINGS X-RAYS-INTRAORAL/EXTRAORAL PROPHYLAXIS(PREVENTIVE) EXCEPT CONE BEAMS**	
Bacteriologic Cultures	None
Viral Cultures	None
Intraoral Bitewing Radiographs Images	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 Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 series of images per calendar year.	
Panorex Radiographs Image Limited to 1 time per consecutive 36 months.	None
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	None
Cone Beam CT Capture and Interpretation with Limited Field of View - Less than One Whole Jaw Limited to 1 time every consecutive 60 months.	50%
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Mandible Limited to 1 time every consecutive 60 months.	50%
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium Limited to 1 time every consecutive 60 months.	50%
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to 1 time every consecutive 60 months.	50%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	None
Extraoral Radiographs Images Limited to 2 images per calendar year.	None
Intraoral - Complete Series of Radiograph Images Limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	None
Intraoral Periapical Radiographs Image	None
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	None

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Intraoral Occlusal Radiographs Image Limited to 2 images per consecutive 6 months.	None
Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	None
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	None
Comprehensive Oral Evaluation Limited to new patients or 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	None
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	None
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	None
Teledentistry - synchronous; real-time encounter Limited to 2 times per consecutive 12 months.	None
Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review Limited to 2 times per consecutive 12 months.	None
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	None
CLASS I **PREVENTIVE SERVICES**	
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	None

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
CLASS II **MINOR RESTORATIVE SERVICES**	
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	50%
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	50%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	50%
CLASS II **ENDODONTICS**	
Apexification Limited to 1 time per tooth per lifetime.	50%
Apicoectomy Limited to 1 time per tooth per lifetime.	50%
Retrograde Filling Limited to 1 time per tooth per lifetime.	50%
Hemisection Limited to 1 time per tooth per lifetime.	50%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.	50%
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	50%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	50%
Therapeutic Pulpotomy	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 time per primary or secondary tooth per lifetime.	
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 per tooth per lifetime. Covered for anterior or posterior teeth only.	50%
Pulp Caps - Direct/Indirect - excluding final restoration Not Covered if utilized solely as a liner or base underneath a restoration.	50%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.	50%
Pulpal Regeneration - (Completion of Regenerative Treatment in an Immature Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limited to 1 per tooth per lifetime.	50%
CLASS II **PERIODONTICS**	
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	50%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	50%
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	50%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	50%
Osseous Surgery	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 per quadrant or site per consecutive 36 months.	
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	50%
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	50%
Surgical Revision Procedure Limited to 1 per quadrant per consecutive 36 months.	50%
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	50%
Full Mouth Debridement Limited to once per consecutive 36 months.	50%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	50%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	50%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing	50%
CLASS II **ORAL SURGERY**	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Alveoloplasty	50%
Biopsy Limited to 1 biopsy per site per visit.	50%
Frenectomy/Frenuloplasty	50%
Surgical Incision Limited to 1 per site per visit.	50%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	50%
Removal of Torus Limited to 1 per site per visit.	50%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	50%
Simple Extractions Limited to 1 time per tooth per lifetime.	50%
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	50%
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	50%
Surgical Access, Surgical Exposure or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.	50%
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	50%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	50%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	50%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime. Not Covered if done in conjunction with other bone graft replacement procedures.	50%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	50%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	50%
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	50%
CLASS II **ADJUNCTIVE SERVICES**	
Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. Covered for patients if it is clinically Necessary.	50%
Desensitizing Medicament	50%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Care Services. Covered for patients if it is clinically Necessary.	50%
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	50%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. Covered for patients if it is clinically Necessary.	50%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Occlusal Adjustment	50%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	50%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50%
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	50%
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	50%
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	50%
CLASS III **MAJOR RESTORATIVE SERVICES** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.	
Coping Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	50%
Crowns - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%
Crowns - Restorations	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%
Inlays/Onlays - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%
Pontics Limited to 1 time per tooth per consecutive 60 months.	50%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive 60 months.	50%
Pin Retention Limited to 2 pins per tooth; not Covered in addition to cast restoration. Cast Restoration is defined as inlays and onlays Limited to 1 time per consecutive 60 months.	50%
Post and Cores	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Covered only for teeth that have had root canal therapy.	
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion.	50%
Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	50%
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%
CLASS III **FIXED PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.	
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per consecutive 60 months.	50%
CLASS III **REMOVABLE PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.	
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%
Partial Dentures	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Descriptions and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50%
CLASS III **COSMETIC**	
Labial Veneer (laminate) - Chairside Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%
Labial Veneer (resin laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%
Labial Veneer (porcelain laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%

SAMPLE

Adult Dental Exclusions

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

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section, under the heading *Benefits for Adult 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. Mouthguards: 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 in this section under the Policy.
17. Dental Care Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Policy ends.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Received outside of the United States.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
21. To alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
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.

SAMPLE

24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

25. Orthodontic Services are not covered unless specifically listed in the Schedule of Covered Dental Services. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, 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 within 120 months of initial or supplemental placement.

25. Services that exceed the frequency limitations as identified in this section.

26. For a dental care service that is not rendered or that is not rendered within the scope of the dentist's license.

27. As a result of dental care services arising out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

    a. Dental care services necessitated due to any act of declared or undeclared war.

    b. The covered person taking part in a riot.

    c. The covered person's commission of a felony for which the covered person is charged.

28. Provided without cost to a covered person in the absence of insurance covering the charge.

29. Maxillofacial prosthetics and related services.

30. Sealants, fluoride treatment and space maintainers for teeth.

31. Provisional crown/retainer crown, provisional pontic, post removal, temporary crown, and coping.

32. Endodontic implants and intentional reimplantation.

33. Precision attachments, personalization, precious metal bases and other specialized techniques.

34. Oral hygiene instructions; plaque control; nutritional counseling; tobacco counseling; charges for completing dental claim forms; charges for copies of your records, charts or x-rays; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; treatment of halitosis and any related procedures; and lab procedures.

35. Interim complete denture and interim partial denture.

36. 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 dentist. If replacement is due to patient non-compliance, the patient is liable for the cost of the replacement.

37. Desensitizing medicament or resin; local anesthesia; regional and trigeminal division block anesthesia; non-intravenous conscious sedation; analgesia, anxiolysis, and inhalation of nitrous oxide.

38. When two or more dental care services are submitted and the dental care services are considered part of the same dental care service to one another, we will pay the most comprehensive dental care service.

39. When two or more dental care services are submitted on the same day and the dental care services are considered mutually exclusive (when one dental care service contradicts the need for the other dental care service), we will pay for the dental care service that represents the final treatment.

40. Any dental care services for which benefits are payable under a medical policy issued by us.

SAMPLE

Defined Terms for Adult Dental Care Services

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

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Policy 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: Adult Dental Care Services*.

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 Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Care Services and supplies under this *Section: Adult Dental Care Services* 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*.

SAMPLE

(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.

Maximum Benefit - the maximum amount paid for Covered Dental Care Services during a calendar year for you under this section or any Amendment or Policy, issued by us that replaces this section.

Section 14: Adult Vision Care Services

This section provides Benefits for routine vision services, as described below, for Covered Persons age 19 and older. Benefits under this section will end on the last day of the calendar year.

What Are Defined Terms?

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

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

Accessing Adult Vision Care Services

Benefits are available for 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 1-877-265-9199. 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.

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Vision Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this section does not apply to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*. Any amount you pay in Co-payments for Vision Care Services under this section does not apply to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

SAMPLE

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 Co-payments 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.
- Refraction - to determine power of corrective lenses for distance and near vision.
- 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.

Benefits for eye exams required for the diagnosis and treatment of a Sickness or Injury are provided in the Policy under *Physician's Office Services - Sickness and Injury*.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

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.

Covered Contact Lens Formulary – a selection of available contact lenses that may be obtained from a Network Vision Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Retinal Photography

Film or digital pictures taken of the back of your eye, which includes the retina and optic nerve.

SAMPLE

Schedule of Benefits

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam for Covered Persons 19 years of age and older	Once every 12 months.	Copayment of $10
Retinal Photography	Once every 12 months.	Copayment of $39
Eyeglass Lenses	Once every 12 months.	
Single Vision		Copayment of $25
Bifocal		Copayment of $25
Trifocal		Copayment of $25
Lenticular		Copayment of $25
Optional Lens Extras* **Coverage for some Optional Lens Extras, which may include progressive lenses, may be included with eyeglass packages offered at some Network locations.*	Once every 12 months.	
Standard Scratch Coating		None
Eyeglass Frames ***Up to $130***	Once every 12 months.	None
Contact Lenses* **If Contact Lenses that are not on the Formulary are prescribed; the member will be responsible for the Contact Lens Fitting and Evaluation - Coverage for Covered Contact Lens Formulary will not apply at Walmart, Sam's Club, and Costco locations. Other Network locations may not offer Formulary contact lenses. In those cases, your allowance for Contact Lenses that are not on the Formulary will apply.*	Once every 12 months	
Contact Lenses Formulary ***Up to 4 boxes*** *(In lieu of glasses)*		Copayment of $25

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate
Includes Fitting and Evaluation		
Contact Lenses Non-Formulary *(In lieu of glasses)* Up to $105 allowance		None

SAMPLE

Adult Vision Exclusions

Except as may be specifically provided in this section, under the heading *Accessing Adult 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 *Policy*.
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 this section, under the heading *Accessing Adult Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Technological devices such as smart phones and tablets.

SAMPLE

Defined Terms for Adult Vision Care Services

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

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 Network - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

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

Vision Care Service - any service or item listed in this section, under the heading *Accessing Adult Vision Care Services.*

SAMPLE