

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

INFORMATION SYSTEMS SERVICES GROUP, INC.

Group Number: GA1U4384IM **Health Plan:** AD - 2G **Prescription Code:** G1
Effective Date: September 1, 2016

Offered and Underwritten by
UnitedHealthcare Insurance Company

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

Certificate of Coverage

UnitedHealthcare Insurance Company

185 Asylum Street
Hartford, CT 06103-3408
1-800-357-1371

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

Any conflict between this *Certificate* and the Policy shall be resolved to the most favorable outcome for the Covered Person.

Changes to the Document

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

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

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval. This in no way removes your right to bring legal action, make an appeal, file a grievance or seek relief through the *Missouri Department of Insurance* as described in this *Certificate*.

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

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

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

Introduction to Your Certificate

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

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

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. To obtain prior authorization, call the telephone number for Customer Care on your ID card. Upon receiving a phone call from you, we contact the appropriate providers and facilities, as necessary to determine Medical Necessity and finalize the prior authorization process. You only need to contact us to get the process started. You will be notified of the outcome of the prior authorization request. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to

share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

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

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Ambulance Services

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

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

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

2. Clinical Trials

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

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

- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

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

In the case of treatment under a clinical trial, the treating facility and personnel will have the expertise and training to provide the treatment and treat a sufficient volume of patients. There will be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - ◆ A cooperative group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

- A qualified research entity that meets the criteria for NIG Center support grant eligibility.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Benefits include routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

3. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include any and all CHD surgeries that are clinically appropriate and Medically Necessary to treat conditions such as but not limited to coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

You can contact us for information at the telephone number on your ID card.

4. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

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

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Placement of a crown if such treatment is the only clinically acceptable treatment and, in cases of an Injury, as described above in this section.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

5. Diabetes Services

As required by Missouri state law, coverage is provided for all physician prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of diabetes. Coverage includes persons with gestational, type 1 or type 2 diabetes. Coverage for gestational, type 1 or type 2 diabetes is not subject to any greater deductible or copayment. We will not reduce or eliminate coverage based on a diabetes diagnosis or treatment plan.

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

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

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

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.

6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.

- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage, except for orthotics for newborns. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

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

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

Benefits are available for repairs and replacement, except that:

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

Orthotic Devices

Coverage is provided for orthotic devices. Covered Health Services include the initial purchase, fitting, and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of moveable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to the following:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

Orthotic appliances may be replaced once per year per member when Medically Necessary in the member's situation. However, additional replacements will be allowed for members under age 18 due to rapid growth, or for any member when an appliance is damaged and cannot be repaired.

- Excluded orthotic services include but are not limited to:
- Orthopedic shoes except therapeutic shoes for diabetics.
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- Standard elastic stockings, garter belts, and other supplies not specially made and fitted.
- Garter belts or similar devices.

7. Emergency Health Services - Outpatient

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

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

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

Medically Necessary out-of-area Benefits are available if you are temporarily outside the Service Area and:

- Medically Necessary services are immediately required.
- The condition for which services are required could not be foreseen.
- Your medical condition does not permit return to the Service Area for treatment.
- Services you receive outside the Service Area will be covered until your medical condition permits travel or transport to the Service Area.

8. Hearing Aids

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

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

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

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

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

Hearing Aids for Newborns

Coverage includes hearing aids provided to a newborn for initial amplification following a newborn hearing screening. Coverage includes any necessary rescreening, audiological assessment and follow-up. For the purpose of this newborn hearing aid coverage, a hearing aid is an electronic device worn or implanted for the purpose of amplifying sound and assisting the physiological process of hearing.

9. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

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

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

10. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

You can contact us for information at the telephone number on your ID card.

11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

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

12. Lab, X-Ray and Diagnostics - Outpatient

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

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.*

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

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

Benefits under this section include:

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

14. Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

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

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

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

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

Special Mental Health Programs and Services

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

15. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

16. Pharmaceutical Products - Outpatient

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

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

17. Physician Fees for Surgical and Medical Services

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

18. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

19. Pregnancy - Maternity Services

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

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

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

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

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

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

Early discharge requires that both of the following requirements are met:

- The discharge complies with the guidelines of the *American Academy of Pediatrics* and the *American College of Obstetricians and Gynecologists*.
- The mother and child are provided post-discharge care. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a Physician. Services provided shall include physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory.

20. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- Immunizations for children from birth to age 5 as are provided by the *Department of Health and Senior Services*. Immunizations for children are not subject to any deductible or copayment limits.
- 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*, including child health supervision services. Benefits for child health supervision services will be provided at, but are not limited to, the following age intervals: birth, two weeks, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years and twelve years. Services rendered during a periodic review must be provided by or under the supervision of a single Physician during the course of one visit.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* including mammography screening.

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

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.
- Benefits for screening mammography include:
 - One baseline mammogram for women age 35-39.
 - One mammogram every two years (or more frequently when recommended by the patient's physician) for women age 40-49.
 - One annual mammogram for women age 50 or older.
 - Mammograms for any woman, when recommended by the patient's physician, when such woman, her mother or her sister has a prior history of breast cancer.

- A prostate examination and laboratory tests for cancer for any nonsymptomatic man in accordance with the current *American Cancer Society* guidelines.
- A pelvic examination and Pap smear for any nonsymptomatic woman in accordance with the current *American Cancer Society* guidelines.
- A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person in accordance with the current *American Cancer Society* guidelines.

21. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

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

Benefits are available for repairs and replacement, except that:

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

22. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. Please note that no time limit will be imposed for receiving the prosthetic devices or reconstructive surgery. You can contact us for information at the telephone number on your ID card.

23. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services (including habilitative service), limited to:

- Physical therapy.
- Occupational therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

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

Visit limits shown in the Schedule of Benefits under Rehabilitation Services -Outpatient Therapy do not apply to the treatment of Autism Spectrum Disorders.

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

We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following sudden external Injuries such as car accidents or falls; or sudden internal Injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors.

Habilitative Services

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

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

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

24. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

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

Benefits under this section include:

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

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

25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

26. Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.

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

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

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

Special Substance Use Disorder Programs and Services

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

27. Surgery - Outpatient

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

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

28. Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

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

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

29. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

30. Transplantation Services

Services and supplies for necessary organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Common examples of transplants for which Benefits are available include, but are not limited to, the following procedures:

- Heart transplants.
- Lung transplants.
- Heart/lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem cell transplants.
- Benefits are provided for transplantation services for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols.

Coverage for organ and tissue transplants includes:

- Pre-transplant evaluation.
- Donor search.
- Organ procurement/tissue harvest.
- Transplant procedure.
- Follow-up care for one year after the transplant.

Donor Charges for Organ/Tissue Transplants

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

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.

- Transplant procedures.
- Follow-up care for 90 days after the donation.

We request that you contact us by calling the number on the back of your member identification card to personally speak to a registered nurse (RN) who will help you understand the organ specific requirements for a transplant, which are used to determine if the transplant is Medically Necessary and who can best facilitate transplant services at an appropriate facility based on your specific condition.

31. Urgent Care Center Services

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

32. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office for Covered Persons over the age of 19. Benefits for Covered Persons age 19 and younger are provided as described in the Pediatric Vision Care Services Rider.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

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

33. Wigs

Coverage is provided for wigs only when following cancer treatment. Wigs and other scalp hair prosthesis regardless of the reason for hair loss.

Additional Benefits Required By Missouri or Federal Law

34. Autism Spectrum Disorders Treatment

Benefits are provided for coverage for the diagnosis and treatment of Autism Spectrum Disorders.

We will not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage to you or your Dependent because the individual is diagnosed with Autism Spectrum Disorder.

Coverage provided for Autism Spectrum Disorder is limited to Medically Necessary treatment that is ordered by the Covered Person's treating licensed Physician or licensed psychologist, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, in accordance with a treatment plan.

Upon our request, the treatment plan will include all elements necessary for us to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

Except for inpatient services, we have the right to review the treatment plan if a Covered Person is receiving treatment for an Autism Spectrum Disorder. We have the right to review the treatment plan not more than once every six months unless we and the Covered Person's treating Physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular Covered Person being treated for an Autism Spectrum Disorder and shall not apply to all Covered Persons being treated for Autism Spectrum Disorders by a Physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by us.

Coverage is provided for Medically Necessary Applied Behavior Analysis for a Covered Persons through 18 years of age. There are no limits on the number of visits a Covered Person may make to an Autism Service Provider.

This Autism Spectrum Disorder Treatment benefit shall not be construed as limiting benefits which are otherwise available to a Covered Person under this Policy. The Autism Spectrum Disorder coverage required by Missouri

law shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by us. Covered Health Services may be subject to other general exclusions and limitations of the Policy, not in conflict with the provisions of this Autism Spectrum Disorder Treatment benefit, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of Covered Health Care Services, including review of Medical Necessity and care management; however, coverage for treatment under the Autism Spectrum Disorder Treatment section shall not be denied on the basis that it is educational or habilitative in nature.

If we make payments or reimbursements for Applied Behavior Analysis, such payments or reimbursements shall be made to either:

- The Autism Service Provider, as defined in the Autism Spectrum Disorder Definitions section of *Section 9: Defined Terms*; or.
- The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements for Autism Spectrum Disorder coverage to an Autism Service Provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a Line Therapist under the supervision of such Autism Service Provider or behavior analyst if such services provided by the Line Therapist are included in the treatment plan and are deemed Medically Necessary.

Notwithstanding any other provision of Missouri's law to the contrary, we shall not be held liable for the actions of Line Therapists in the performance of their duties.

Because we are subject to the provisions of Missouri's Autism Spectrum Disorder law, we shall not be required to provide reimbursement for the Applied Behavior Analysis delivered to a person insured by us to the extent we are billed for such services by any Part C early intervention program or any school district for Applied Behavior Analysis rendered to the Covered Person by us. This shall not be construed as affecting any obligation to provide services to a Covered Person who has an individualized family service plan, an individualized education plan, or an individualized service plan. The Missouri's Autism Spectrum Disorder law shall not be construed as affecting any obligation to provide reimbursement pursuant to Missouri's Early Intervention Services law.

35. Chiropractic Services

Benefits for chiropractic services that are delivered by a licensed chiropractor acting within the scope of the Practice of Chiropractic. Services include the initial diagnosis and clinically appropriate and medically indicated services and supplies required to treat the diagnosed disorder. Refer to *Section 2: Exclusions and Limitations* concerning experimental and unproven treatments.

36. Dental Anesthesia and Facility Charges

Administration of general anesthesia and Hospital charges for dental care if:

- The Covered Person is a child under the age of five.
- The Covered Person is severely disabled.
- The Covered Person has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

37. Early Intervention Services

Services for medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the *Individuals with Disabilities Education Act, 20 U.S.C. Section 1431*. Early Intervention services include services for an active individualized family services plan that enhance functional ability without effecting a cure.

38. Enteral Formulas and Low Protein Modified Food Products

Formula and low protein modified food products for Enrolled Dependent children under the age of six when recommended by a Physician for the treatment of phenylketonuria (PKU) or Inherited Metabolic Diseases.

39. Hearing Screenings for Newborns

Hearing screenings for newborns, including rescreening, audiological assessment and follow-up, and initial amplification.

40. Human Leukocyte Testing

Services for human leukocyte testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens to be used in bone marrow transplants. The testing must be performed in a facility which is accredited by the *American Association of Blood Banks* or its successors, the *College of American Pathologists*, the *American Society for Histocompatibility and Immunogenetics (ASHI)* or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the *College of American Pathologists* and be licensed under the *Clinical Laboratory Improvement Act*.

At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the *National Marrow Donor Program*.

41. Lead Poisoning Testing

Services related to the testing for lead poisoning.

42. Osteoporosis services

Services for the diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated.

43. Private Duty Nursing

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

44. Speech and Hearing Services

Services include treatment for loss or impairment of speech or hearing, including those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the *American Speech-Language and Hearing Association (ASHA)* or both, and which fall within the scope of his or her license or certification.

45. Telehealth

Covered Health Services provided through telehealth rather than face-to-face consultation. Covered Health Services include services for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease.

For the purposes of this benefit, "telehealth" means the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.

46. Vision Correction after Surgery

Benefits are provided for vision correction after surgery. Covered Health Services include, but are not limited to Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following

surgery. If the injury is to one eye or if cataracts are removed from only one eye and the member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to chiropractic services or non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Autism Spectrum Disorders Treatment

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

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
3. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
5. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
7. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

C. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as described under *Dental Anesthesia and Facility Charges* in *Section 1: Covered Health Services*).

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

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer, cleft palate or diseases of the mouth and if Injury to the tooth was a serious Injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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

D. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities.
3. Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses. This exclusion does not apply to trusses described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the *Individuals with Disabilities Education Act, 20 U.S.C. Section 1431*.
6. Oral appliances for snoring.
7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

E. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

F. Experimental or Investigational or Unproven Services

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

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

G. Foot Care

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

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

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

H. Medical Supplies

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

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

I. Mental Health

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under *Autism Spectrum Disorders Treatment* in *Section 1: Covered Health Services* consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions identified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under *Enteral Formulas and Low Protein Modified Food Products* in *Section 1: Covered Health Services*.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under *Enteral Formulas and Low Protein Modified Food Products* in *Section 1: Covered Health Services*.

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs, except when provided following cancer treatment.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder.
5. Outpatient cognitive rehabilitation therapy when not Medically Necessary for chronic or progressive conditions such as cerebral palsy, Alzheimer's disease or Parkinson's disease.
6. Psychosurgery.
7. Sex transformation operations and related services.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of dislocation, tumors, cancer, obstructive sleep apnea or a Congenital Anomaly or Injury as described in the Reconstructive Procedures Benefit in Section 1: Covered Health Services.
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
14. In vitro fertilization regardless of the reason for treatment.

N. Providers

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

- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Health Services and associated 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 if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed.
6. Fetal reduction surgery. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female whom the abortion is performed.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

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

Q. Substance Use Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

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

S. Travel

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

T. Types of Care

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

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. 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.
5. Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to *Section 4: When Coverage Ends*.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

If You Are Eligible for Medicare

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

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

Eligible Persons must reside within the United States.

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

Dependent

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

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

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

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

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

Adding New Dependents

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

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

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

Coverage for newborn children of a Covered Person, including adopted newborn children and newborn children placed for adoption, begins at the moment of birth, adoption or placement for adoption. We must receive the completed enrollment form and any required Premium within 31 days of the date of the event. If we do not receive the completed enrollment form and any required Premium within 31 days, coverage for the child will end at the end of the 31 day period.

If an application or other form of enrollment is required in order to continue coverage beyond the 31 day period after the date of the event and the Covered Person has notified us of the event, either orally or in writing, we shall, upon notification, provide the Subscriber with all forms and instructions necessary to enroll the child. You will have an additional ten days from the date the forms and instructions are provided in which to enroll the child.

Special Enrollment Period

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

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

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

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

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

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

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

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

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Continuation of Coverage (Federal and State) and Conversion

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

Because Missouri has adopted the COBRA laws as their state continuation laws, COBRA now applies to all Missouri employer groups who would not otherwise be subject to federal COBRA. Regardless of employer group size, employer groups who are issued a Missouri Policy by a Missouri insurance carrier that is subject to the requirements of Missouri insurance laws, federal COBRA applies. Whenever we use the term COBRA in this Policy, it will mean that it applies to all Missouri employer groups whose policies are issued by a Missouri insurer who is subject to Missouri insurance laws.

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

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

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

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

Continuation Coverage After COBRA Ends

Persons Eligible for Continuation of Coverage After COBRA Ends

You have the right to continue coverage after COBRA expires if the Enrolling Group has more than 20 employees or members and you are either a surviving spouse age 55 or older or a divorced or legally separated spouse age 55 or older, as described below.

Surviving Spouse Age 55 or Older

The surviving spouse of a Subscriber may continue coverage under the Policy, upon death of the Subscriber, with respect to the spouse and any Enrolled Dependent children whose coverage under the Policy otherwise would terminate because of the death of the Subscriber if the surviving spouse is 55 years of age or older at the time of the expiration of coverage provided by the COBRA.

Continued coverage for dental, vision care or prescription drug expenses shall be offered to surviving spouses and any Enrolled Dependent children eligible as described in this section if such coverage is or was available to the Subscriber.

The Enrolling Group shall provide us with written notice of the death of the Subscriber and of the mailing address of the surviving spouse. The notice must be sent within 30 days of either of the following:

- The death of a Subscriber whose surviving spouse is eligible for continued coverage under this section.
- Prior to the expiration of a 36-month COBRA continuation period covering such surviving spouse, if such spouse has elected and maintained such COBRA coverage.

Within 14 days of receipt of notice, the plan administrator shall notify the surviving spouse that coverage under the Policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include all of the following:

- A form for election to continue the coverage.
- A statement of the amount of periodic Premiums to be charged for the continuation of coverage and of the method and place of payment.
- Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

Divorced or Legally Separated Spouse Age 55 or Older

The divorced or legally separated spouse of a Subscriber may continue coverage under the Policy, upon dissolution of marriage with, or legal separation from, the Subscriber, with respect to the divorced or legally separated spouse and any Enrolled Dependent children whose coverage under the Policy otherwise would terminate because of the dissolution of marriage or legal separation, if the divorced or legally separated spouse is 55 years of age or older at the time of the expiration of coverage provided by the COBRA.

Continued coverage for dental, vision care or prescription drug expenses shall be offered to divorced or legally separated spouses and any Enrolled Dependent children eligible as described in this section if such coverage is or was available to the Subscriber.

A divorced or legally separated spouse eligible for continued coverage under this section who seeks such coverage shall provide us written notice of the legal separation or dissolution. The notice shall include the mailing address of the divorced or legally separated spouse. The notice must be sent within 60 days of any of the following:

- Legal separation.
- The entry of a decree of dissolution of marriage.
- Prior to the expiration of a 36-month COBRA continuation period covering a divorced or legally separated spouse if such spouse has elected and maintained such COBRA coverage.

Within 14 days of receipt of notice, the plan administrator shall notify the divorced or legally separated spouse that coverage under the Policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include all of the following:

- A form for election to continue the coverage.
- A statement of the amount of periodic Premiums to be charged for the continuation of coverage and of the method and place of payment.
- Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

Failure to Follow Election Process

Failure of the divorced, legally separated or surviving spouse to exercise the election in accordance with the notice requirements described above will terminate their right to continuation of coverage.

If a plan administrator was properly notified, as described above, and fails to the divorced, legally separated or surviving spouse as required, such spouse's coverage shall continue in effect, and such spouse's obligation to make any Premium payment for such continuation coverage shall be postponed for the period of time beginning on the date the spouse's coverage would otherwise terminate and ending 31-days after the date the plan administrator provide the required notice. Failure or delay by the plan administrator in providing the notice required by this section shall not reduce, eliminate or postpone the plan sponsor's obligation to pay Premiums on behalf of such divorced, legally separated or surviving spouse.

Your continued coverage shall terminate on the earlier of the following dates:

- A. The date coverage terminates for failure to make timely payment of the Premium.
- B. The date the Policy ends, except that if a different policy is made available to Subscribers, the divorced, legally separated or surviving spouse shall be eligible for continuation of coverage as if the original Policy had not been terminated.
- C. The date the Covered Person is insured under any other group health plan.
- D. The date the Covered Person attains the age of 65.

Premiums

The monthly contribution for the Premium shall be paid by the divorced, legally separated or surviving spouse within 45 days of the date of the election. The Premium amount shall not be greater than the amount that would have been charged if the divorced, legally separated or surviving spouse were a current Covered Person under the Policy, plus the amount the Subscriber would contribute toward the Premium if the divorced, legally separated or surviving spouse were a Subscriber, plus an amount not to exceed 25% of the Covered Person and Subscriber contributions. Such additional contributions shall be determined by each plan administrator and shall be subject to review by the *Missouri Department of Insurance*.

Termination

The right to continuation of coverage shall terminate upon the earliest of any of the following:

- The failure to pay Premiums when due, including any grace period allowed by the Policy.
- The date that the Policy is terminated as to all group members except that if a different policy is made available to group members, the divorced, legally separated or surviving spouse shall be eligible for continuation of coverage as if the original policy had not been terminated.
- The date on which the divorced, legally separated or surviving spouse becomes insured under any other group health plan.
- The date on which the divorced, legally separated or surviving spouse remarries and becomes insured under another group health plan.
- The date on which the divorced, legally separated or surviving spouse attains his or her 65th birthday.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation (COBRA federal or state) coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

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

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

Written proofs of loss must be provided to us within 90 days after the date of the loss. Failure to furnish proof within the time frame shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

All Benefits payable under the Policy shall be payable not more than 30 days after receipt of proof.

Required Information

You do not need to fill out a specific claim form, however, when you request payment of Benefits from us, you must provide us with all of the following information:

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

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Payment of Benefits

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

Direct Payment to Public Hospitals

Benefits for Covered Health Services will be paid, with or without an assignment from you, to public Hospitals or clinics for services and supplies provided to you if a proper claim is submitted by the public Hospital or clinic. No Benefits shall be paid under this section to the public Hospital or clinic if such Benefits have been paid to you prior to receipt of the claim by us. Payment to the public Hospital or clinic shall discharge us from all liability to you to the extent of the Benefits paid.

Section 6: Questions, Grievances and Appeals

Definitions

The following terms apply to this Section:

"Adverse determination" means a determination by us or our designee utilization review organization that an admission, availability of care, continued stay or other health care services has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated.

"Grievance" means a written complaint by or on behalf of an enrollee regarding the:

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

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

What to Do if You Have a Question

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

First Level Grievance Procedure

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

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written grievance. You may also designate a representative to submit a grievance for you. The *Customer Care* representative can provide you with the appropriate address to submit your written grievance.

We will acknowledge receipt of the grievance in writing within 10 working days unless the grievance has been resolved prior to that time. Our authorized representative shall contact you and attempt to resolve the issue through informal communications.

Investigation

We will conduct a complete investigation of the grievance within 20 working days after receipt of the grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of the grievance, we will notify you in writing on or before the 20th working day and the investigation shall be completed within 30 working days thereafter. The notice will set forth the reasons for which additional time is needed for the investigation.

Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance and notify you in writing of our decision regarding the grievance and of the right to appeal for a second level review. The notice shall explain the resolution of the grievance and of the right to file an appeal in terms that are clear and specific. Within 15 days after the investigation is complete, we will notify you or the person who submitted the grievance on your behalf.

Second Level by Grievance Advisory Panel

If you still disagree with our determination, you can submit a written request for a second review. Upon receipt of the request for a second review, we shall submit the grievance to a grievance advisory panel consisting of:

- Other Subscribers.
- Representatives of ours that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.
- When the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

Review by the grievance advisory panel will follow the same time frames as set forth above, except for expedited review as described below.

The grievance advisory panel shall advise you in writing of its findings within 15 days from the conclusion of the hearing.

At any time during this process you have the right to take your grievance to the *Missouri Department of Insurance*. You can contact the *Missouri Department of Insurance* by calling their consumer complaint hotline at 800-726-7390 or by writing to the *Missouri Department of Insurance* at:

Missouri Department of Insurance
Consumer Services Section
P.O. Box 690,
Jefferson City, Missouri 65102-0690

Expedited Review

If you have a dispute about a health care service that if left untreated would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function and requires special consideration as an expedited review, the above sections do not apply. Your expedited grievance may be submitted orally or in writing. For the purposes of the grievance register, the request will not be considered a grievance unless it is in writing. The expedited review procedures are available to you, your representative, and a provider acting on your behalf. Please note that prescheduled treatments, therapies, surgeries, or other procedures are not considered urgent situations, unless the delivery of the prescheduled medical service changes and becomes urgent.

We will notify you verbally of our determination within 72 hours after receiving a request for an expedited review. We will provide a written confirmation of our determination within 3 working days after we have verbally notified you.

If you are dissatisfied with our determination, you have the right to take your grievance to the *Missouri Department of Insurance*. You can contact the *Missouri Department of Insurance* by calling their consumer complaint hotline at 800-726-7390 or by writing to the *Missouri Department of Insurance* at:

Missouri Department of Insurance
Consumer Services Section
P.O. Box 690,
Jefferson City, Missouri 65102-0690

Utilization Review

Utilization review is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

Pharmaceutical and Durable Medical Equipment

In addition to all other reviews, you, or your provider on your behalf, may appeal for the coverage of Medically Necessary pharmaceutical prescriptions and Durable Medical Equipment using our utilization review process.

Initial Determinations

For initial determinations, we shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, we shall notify the provider rendering the service by telephone within 24 hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the enrollee and the provider within two working days of making the initial certification.

In the case of an adverse determination, we shall notify the provider rendering the service by telephone within 24 hours of making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider within one working day of making the adverse determination.

If we authorize a health care service, we will not later retract its authorization after the services have been provided, or reduce payment for an item or service furnished due to this authorization unless:

- The authorization is based on a material misrepresentation or omission about the enrollee's health condition.
- The plan terminates before the services are provided.
- The enrollee's coverage under the plan terminates before services are provided.

Determinations for Emergency Services

Emergency services necessary to screen and stabilize a member do not require prior authorization. Emergency services are subject to any applicable Copayments and/or Coinsurance. When emergency services require immediate post evaluation or post stabilization services, we will provide an authorization decision within sixty minutes of receiving the request; if the authorization decision is not made within thirty minutes, services will be deemed approved.

Concurrent Review Determinations

For concurrent review determinations, we shall make the determination within one working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, we shall notify the provider rendering the service by telephone within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case if an adverse determination, we shall notify the provider rendering the service by telephone within 24 hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of the telephone notification. The services shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

Retrospective Review Determinations

For retrospective review determinations, we shall make the determination within 30 working days of receiving all necessary information. We shall provide notice in writing of our determination to an enrollee within ten working days of making the determination.

Adverse Determination

A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. We shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

Appeal of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, we shall give the provider rendering the service an opportunity to request, on behalf of the enrollee, a reconsideration of an adverse determination by the reviewer making the adverse determination.

The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer who made the adverse determination if the reviewer who made the adverse determination is not available within one working day.

If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider on behalf of the enrollee. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Lack of Information

We have written procedures to address failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, we may deny certification of an admission, procedure or service.

Independent External Review Program

Definitions

"Director" means the director of the department of insurance, financial institutions and professional registration.

"Division" as used herein means the Division of Consumer Affairs as established by the Director pursuant to Missouri law.

"Enrollee's Representative" or "Representative" means:

- A person to whom an enrollee has given express written consent to represent the enrollee in an external review.
- A person authorized by law to provide substituted consent for an enrollee; or
- A family member of the enrollee or the enrollee's treating health care professionals only when the enrollee is unable to provide consent.

When a health carrier or their designee utilization review organization issues an adverse determination, as defined above, to an enrollee in a health plan that has a managed care component, the enrollee or his/her representative may file a grievance with the director without exhausting all remedies available under the carrier's grievance process.

A health carrier or plan sponsor also may file a grievance with the director concerning an adverse determination.

1. The grievance will be processed by the division as any other consumer complaint. The division will assign the grievance a file number. The division will send an inquiry to the health carrier (or party) which is complained against requesting the health carrier (or party) to respond in writing with their position and all supporting documentation concerning the matter grieved. The division will attempt to resolve the issue with the health carrier (or party).

2. If the director determines a grievance is unresolved after completion of the division's consumer complaint process, the director shall refer the unresolved grievance to an independent review organization (IRO). An unresolved grievance shall include a difference of opinion between a treating health care professional and the health carrier concerning the medical necessity, appropriateness, health care setting, and level of care or effectiveness of a health care service.
3. The director will provide the IRO and the enrollee, enrollee's representative or health carrier copies of all medical records and any other relevant documents which the division has received from any party. The enrollee, enrollee's representative and health carrier may review all the information submitted to the IRO for consideration.
4. The enrollee, enrollee's representative or health carrier may also submit additional information to the division which the division shall forward to the IRO. All additional information must be received by the division. If an enrollee, enrollee's representative or health carrier has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the division within 15 working days from the date the division mailed that party copies of the information provided the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the division by means other than mail if it is in writing, typeset or easily transferred into typeset by the division's technology and a date of transmission is easily determined by the division. Any additional information submitted by the enrollee or the enrollee's representative shall be reviewed by the IRO when conducting the external review. At the director's discretion, additional information which is received past the 15 working-day deadline may be submitted to the IRO.
5. The IRO shall request from the division any additional information it wants. The division shall gather the requested information from an enrollee, enrollee's representative or health carrier or other appropriate entity and provide it to the IRO. If the division is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.
6. Within 20 calendar days of the receipt of the request for external review, the IRO shall submit to the director its opinion of the issues reviewed. If Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed 5 calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.
7. After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the enrollee and the health carrier. The director's decision shall be in writing and must be provided to the enrollee and health carrier within 25 calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the enrollee and the health carrier are notified of the director's decision be longer than 45 days.

Expedited External Review

An enrollee or enrollee's representative or health carrier may request an expedited external review if the adverse determination:

1. Concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services, but has not been discharged from a facility; or
2. Involves a medical condition for which the delay occasioned by the standard external review time frame would jeopardize the life or health of the enrollee or jeopardize the enrollee's prognosis or ability to regain maximum function.

As expeditiously as possible after receipt of the request for expedited external review by the IRO, the IRO must issue its opinion as to whether the adverse determination should be upheld or reversed and submit its opinion to the director. As expeditiously as possible, but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the director shall issue notice to the enrollee and the health carrier of the director's determination and may issue a decision to uphold or reverse the adverse determination.

If the notice is not in writing, the director must provide the written decision within 48 hours after the date of the notice of the determination.

External Review of Experimental or Investigational Services

If a request for external review of an adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the following additional requirements must be met:

1. The IRO shall make a preliminary determination as to whether the recommended or requested health care service or treatment that is the subject of the adverse determination is a covered benefit under the person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and is not explicitly listed as an excluded benefit under the enrollee's health benefit plan with the health carrier.
2. The request for external review of an adverse determination involving a denial of coverage based on a health carrier's determination that the health care service or treatment recommended or requested is experimental or investigational must include a certification from the enrollee's physician that:
 - A. Standard health care services or treatments have not been effective in improving the condition of the enrollee; or
 - B. Standard health care services or treatments are not medically appropriate for the enrollee; or
 - C. There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and
 - D. The request for external review of an adverse determination involving the denial of coverage based on a determination that the requested treatment is experimental or investigational shall also include documentation a) that the enrollee's treating physician has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than any available standard health care services or treatments; or b) that the enrollee's treating physician, who is a licensed, board certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the enrollee that is the subject of the adverse determination is likely to be more beneficial to the enrollee than any available standard health care services or treatments.
3. When conducting such an external review, the IRO must select one or more clinical peers, who must be physicians or other health care professionals who meet minimum qualifications and through clinical experience in the past 3 years are experts in the treatment of the enrollee's condition and knowledgeable about the recommended or requested health care service or treatment. Each clinical peer shall provide a written opinion to the assigned IRO on whether the recommended or requested health care service or treatment should be covered.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent

(e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
 - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits,

this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

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

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

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.

We will not request a refund or offset against a claim more than twelve months after the claim has been paid, except in cases of fraud or misrepresentation by the provider.

When Medicare is Secondary

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

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

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

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

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

Our Relationship with Providers and Enrolling Groups

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

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

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

The Enrolling Group is solely responsible for all of the following:

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

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

Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

Notice

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

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

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

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility.

Interpretation of Benefits

We have the discretion to do all of the following:

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

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

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

This in no way removes your right to bring legal action, make an appeal, file a grievance or seek relief through the *Missouri Department of Insurance* as described in this *Certificate*.

Administrative Services

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

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

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

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

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may

use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Medicare Eligibility

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

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

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

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

Refund of Overpayments

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

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

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

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

Please note that we shall not request a refund or offset against a claim more than twelve months after the claim has been paid, except in cases of fraud or misrepresentation by the provider.

Limitation of Action

We strongly encourage you to complete the steps specified in *Section 6: Questions, Grievances and Appeals* prior to bringing any legal proceeding or action against us. If you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

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

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

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

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

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

Autism Spectrum Disorder Definitions

Applied Behavior Analysis - the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

Autism Service Provider - any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board certified behavior analyst.

Autism Spectrum Disorders - a neurobiological disorder, an illness of the nervous system, which includes *Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), Rett's Disorder and Childhood Disintegrative Disorder*, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*.

Diagnosis of Autism Spectrum Disorders - medically necessary assessments, evaluations, or tests used in order to diagnose whether an individual has an Autism Spectrum Disorder.

Habilitative or Rehabilitative Care - professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.

Line Therapist - an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

Pharmacy Care - medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

Psychiatric Care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care - direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care - services provided by licensed speech therapists, occupational therapists or physical therapists.

Treatment for Autism Spectrum Disorders - care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including, equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

- Psychiatric Care;
- Psychological Care;
- Habilitative or Rehabilitative Care, including Applied Behavior Analysis therapy;
- Therapeutic Care;
- Pharmacy Care.

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

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

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

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

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

- The applicable Copayment.
- The Eligible Expense.

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

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

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

Custodial Care - services that are any of the following:

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

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

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Medical Condition - the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average

knowledge of medicine and health, to believe that immediate medical care is required which may include any of the following:

- Placing the person's health in significant jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.
- Inadequately controlled pain.
- With respect to a pregnant woman who is having contractions, either of the following:
 - Inadequate time to effect a safe transfer of a pregnant woman to another hospital before delivery.
 - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Health Services - health care services and supplies necessary for the screening and treatment of an Emergency Medical Condition.

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance 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 considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

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

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

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

Hospital - a legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a Hospital.

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

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

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

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

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

Intermittent Care - skilled nursing care that is provided or needed either:

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

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

Low Protein Modified Food Product - a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein.

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

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) 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 reserve 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 made by us or our designee.

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

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

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

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the most recent *Diagnostic and Statistical Manual of the American Psychiatric Association*, except for chemical dependency.

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

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

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

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

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

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

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

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

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

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

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

Please Note: Any 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.

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

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

- Amendments.

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

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

Practice of Chiropractic - the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board. It does not include the use of operative surgery, obstetrics, osteopathy, podiatry, or the administration or prescribing of any drug or medicine or the practice of medicine.

Pregnancy - includes all of the following:

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

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

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

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

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

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

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, Pediatric Vision Care Services and Pediatric Dental Services, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only

when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* 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 Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

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

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

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance related and addictive disorders that are listed in the most recent *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered

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

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

Certificate of Coverage Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below, through the following changes to the *Certificate of Coverage (Certificate)*.

1. *Section 1: Covered Health Services* is modified by replacing *Rehabilitation Services - Outpatient Therapy* with the following:

23. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services (including habilitative services), limited to:

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

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

Visit limits shown in the Schedule of Benefits under Rehabilitation Services -Outpatient Therapy do not apply to the treatment of Autism Spectrum Disorders.

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

We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following sudden external Injuries such as car accidents or falls; or sudden internal Injuries such as stroke (cerebral vascular accident), aneurysm, anoxia, encephalitis or brain tumors.

Habilitative Services

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

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

2. The following Benefit for *Virtual Visits* is added to *Section 1: Covered Health Services*:

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a *Designated Virtual Network Provider*. You can find a *Designated Virtual Network Provider* by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

For purposes of this Benefit, the following definition applies:

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 Services via interactive audio and video modalities.

3. *Section 2: Exclusions and Limitations* is modified by replacing the exclusions for *Drugs, Mental Health, Neurobiological Disorders - Autism Spectrum Disorder* and *Substance Use Disorders* with the following exclusions:

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

I. Mental Health

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

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under *Autism Spectrum Disorders Treatment* in *Section 1: Covered Health Services* consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions identified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Q. Substance Use Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.

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

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to be 'John J. ...', written over a horizontal line.

President

Small Business Health Options Program Off-Exchange Qualified Health Plan Certificate of Coverage Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the *Certificate of Coverage (Certificate)* is modified to support coverage for Enrolling Groups that wish to purchase the same Qualified Health Plan coverage off the Small Business Health Options Program (SHOP) exchange.

1. The provision ***Certificate of Coverage is Part of Policy*** is replaced with the following:

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

2. The provision ***Be Enrolled and Pay Required Contributions under Your Responsibilities*** is replaced with the following:

Be Enrolled and Pay Required Contributions

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

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

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

3. ***Section 3: When Coverage Begins*** is replaced in its entirety with the following:

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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

Eligible Persons must reside within the United States.

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

Dependent

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

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

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

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

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

Adding New Dependents

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

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

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

Special Enrollment Period

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

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

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

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

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

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

- The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

4. Section 4: When Coverage Ends is modified by replacing Events Ending Your Coverage with the following:

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **We Terminate as a Qualified Health Plan Issuer**

Your coverage ends on the date we terminate as a Qualified Health Plan Issuer.

- **The Benefit Plan is Decertified as a Qualified Health Plan**

Your coverage ends on the date the benefit plan is decertified as a Qualified Health Plan.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

5. Section 9: Defined Terms is modified by adding the definitions of Initial Enrollment Period and Open Enrollment Period and by replacing the definitions of Eligible Person and Enrolling Group as follows:

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

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

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

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

UnitedHealthcare Insurance Company



President

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

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

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits*.

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

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

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

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

Prior Authorization

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

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process. Upon receiving a phone call from you or your representative, we will contact the

appropriate providers and facilities, as necessary to determine Medical Necessity and finalize the prior authorization process. You only need to contact us to get the process started. You will be notified of the outcome of the prior authorization request.

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Autism Spectrum Disorders treatment.
- Clinical trials.
- Congenital heart disease surgery.
- Dental anesthesia and facility charges.
- Dental services - accidental.
- Diabetes equipment - insulin pumps over \$1,000.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Early intervention services.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-ray and diagnostics - sleep studies.
- Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Private Duty Nursing.
- Prosthetic devices over \$1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services - physical therapy, occupational therapy and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - only for the following outpatient surgeries: diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Telehealth.
- Temporomandibular joint services.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound.

- Transplants.
- Vision Correction after Surgery.

After you contact us for prior authorization, we will identify the Benefit level available to you.

Our clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

Annual Deductibles are calculated on a Policy year basis.

Out-of-Pocket Maximums are calculated on a Policy year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Network</p> <p>\$1,000 per Covered Person, not to exceed \$2,000 for all Covered Persons in a family.</p> <p>You are not required to satisfy the Annual Deductible before receiving Benefits for immunizations for Enrolled Dependent children from birth to age 5.</p> <p>Non-Network</p> <p>\$3,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>You are not required to satisfy the Annual Deductible before receiving Benefits for immunizations for Enrolled Dependent children from birth to age 5.</p>
Out-of-Pocket Maximum	
<p>The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization as required. 	<p>Network</p> <p>\$4,000 per Covered Person, not to exceed \$8,000 for all Covered Persons in a family.</p> <p>Non-Network</p> <p>\$8,000 per Covered Person, not to exceed \$16,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p>

Payment Term And Description	Amounts
<ul style="list-style-type: none"> • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. 	
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<p>Coinsurance</p>	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			

Prior Authorization Requirement

In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Ambulance	Network <i>Ground Ambulance:</i> 100%	Yes	Yes
	<i>Air Ambulance:</i> 100%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	Network <i>Ground Ambulance:</i> 100%	Yes	Yes
	<i>Air Ambulance:</i> 100%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
2. Clinical Trials			

Prior Authorization Requirement

You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

<p>Benefit limits for routine care services for clinical trials are the same as limits for similar routine care services for any other physical Sickness.</p>	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for a clinical trial during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for a Physician's office visit associated with a clinical trial will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for laboratory services associated with a clinical trial will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. <p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for a clinical trial during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for a Physician's office visit associated with a clinical trial will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for laboratory services associated with a clinical trial will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>.
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
3. Congenital Heart Disease Surgeries			

Prior Authorization Requirement

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

Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be provided on the same basis as similar services for any other physical Sickness.	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

4. Dental Services - Accident Only			
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Prior Authorization Requirement

For Network and Non-Network Benefits you must obtain prior authorization. Please call at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.

	Network 100%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
5. Diabetes Services			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.

<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p>	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for diabetic eye examinations performed in a Physician’s office will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for a Physician’s office visit associated with diabetes self-management and training will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for diabetic foot care for surgeries performed on an outpatient basis will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>.
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for diabetic eye examinations performed in a Physician’s office will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for a Physician’s office visit associated with diabetes self-management and training will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for diabetic foot care for surgeries

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	performed on an outpatient basis will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i> .		
<p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i>.</p>	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for diabetes self-management Items related to Durable Medical Equipment will be the same as found under <i>Durable Medical Equipment</i> in this <i>Schedule of Benefits</i>. • Benefits for diabetes self-management items related to prescribed items obtained at a pharmacy can be found in the <i>Outpatient Prescription Drug Rider</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for diabetes self-management Items related to Durable Medical Equipment will be the same as found under <i>Durable Medical Equipment</i> in this <i>Schedule of Benefits</i>. • Benefits for diabetes self-management items related to prescribed items obtained at a pharmacy can be found in the <i>Outpatient Prescription Drug Rider</i>. 		
<p>6. Durable Medical Equipment</p>			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes
7. Emergency Health Services - Outpatient			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i>. As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.</p>	Network 100% after you pay a Copayment of \$300 per visit . If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	Yes	No
	Non-Network Same as Network	Same as Network	Same as Network

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
8. Hearing Aids			
Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. Limits do not apply to hearing aids for newborns.	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes
9. Home Health Care			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization. For a scheduled admission, please call to request prior authorization at least five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.			
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.	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
10. Hospice Care			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization. For a scheduled admission, please call to request prior authorization at least five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.

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

	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

11. Hospital - Inpatient Stay			
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Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission, you must obtain prior authorization. For a scheduled admission, please request prior authorization at least five business days before admission. For non-scheduled admissions (including Emergency admissions), you must notify us as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. For Emergency admissions, we must be notified as soon as is reasonably possible.

	Network 100%	Yes	Yes
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 70%	Yes	Yes

12. Lab, X-Ray and Diagnostics - Outpatient

Prior Authorization Requirement

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

Lab Testing - Outpatient:	Network 100%	Yes	No
	Non-Network 70%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	Network 100%	Yes	No
	Non-Network 70%	Yes	Yes

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

14. Mental Health Services

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.

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

If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.

	Network <i>Inpatient</i> 100%	Yes	Yes
	<i>Outpatient</i> 100% after you pay a Copayment per visit of \$40 100% for Partial Hospitalization/	Yes Yes	No Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Intensive Outpatient Treatment		
	Non-Network <i>Inpatient</i> 70%	Yes	Yes
	<i>Outpatient</i> 70%	Yes	Yes
	70% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
15. Ostomy Supplies			
	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes
16. Pharmaceutical Products - Outpatient			
	Network 100%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 70%	Yes	Yes
17. Physician Fees for Surgical and Medical Services			
Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i> . As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes
18. Physician's Office Services - Sickness and Injury			
<p style="text-align: center;">Prior Authorization Requirement</p> <p style="text-align: center;">For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described 	Network 100% after you pay a Copayment of \$40 per visit for a Primary	Yes	No

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i></p> <ul style="list-style-type: none"> • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i> • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i> • Outpatient surgery procedures described under <i>Surgery - Outpatient.</i> • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i> 	Physician office visit or \$80 per visit for a Specialist Physician office visit		
	Non-Network 70%	Yes	Yes

19. Pregnancy - Maternity Services

Prior Authorization Requirement

For Non-Network Benefits you must notify us as soon as is reasonably possible when the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as soon as is reasonably possible, as required, Benefits will be reduced to 50% of Eligible Expenses.

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

An Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.

Network
Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:

- Benefits for Pregnancy during an Inpatient Stay in a Hospital will be the same as found under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*
- Benefits for laboratory services associated with

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Pregnancy will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>.</p> <ul style="list-style-type: none"> Benefits for pharmaceutical products for Pregnancy received on an outpatient basis will be the same as found under <i>Pharmaceutical Products - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> Benefits for Pregnancy during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. Benefits for laboratory services associated with Pregnancy will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. Benefits for pharmaceutical products for Pregnancy received on an outpatient basis will be the same as found under <i>Pharmaceutical Products - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
20. Preventive Care Services			
<p>Physician office services</p> <p>You are not required to pay any Copayments or Coinsurance or meet any deductible for immunizations for Enrolled Dependent children from birth to age five.</p>	<p>Network</p> <p>100%</p>	<p>No</p>	<p>No</p>
	<p>Non-Network</p> <p>70%</p> <p>100% for child immunizations to age five.</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Lab, X-ray or other preventive tests	Network 100%	No	No
	Non-Network 70%	Yes	Yes
Breast pumps	Network 100%	No	No
	Non-Network 70%	Yes	Yes
21. Prosthetic and Orthotic Devices			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
22. Reconstructive Procedures			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization. For a scheduled admission, please call to request prior authorization at least five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead in an Emergency situation notify us as soon as is reasonably possible.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions. For Emergency admissions, we must be notified as soon as reasonably possible.

	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for reconstructive procedures during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for reconstructive procedures during outpatient surgery will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>. • Benefits for reconstructive procedures received during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>.
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	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for reconstructive procedures during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for reconstructive procedures during outpatient surgery will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>.
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<ul style="list-style-type: none"> Benefits for reconstructive procedures received during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. 		
23. Rehabilitation Services - Outpatient Therapy			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>Limited per year as follows:</p> <ul style="list-style-type: none"> 25 visits of physical therapy. 25 visits of occupational therapy. 25 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. <p>These limits do not apply to Therapeutic Care for Treatment of Autism Spectrum Disorder.</p>	<p>Network</p> <p>100% after you pay a Copayment of \$40 per visit</p>	<p>Yes</p>	<p>No</p>
	<p>Non-Network</p> <p>70%</p>	<p>Yes</p>	<p>Yes</p>
24. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	<p>Network</p> <p>100%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 70%	Yes	Yes
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization. For a scheduled admission, please call to request prior authorization five business days before admission. For non-scheduled admissions, you must notify us as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. For Emergency admissions, we must be notified as soon as is reasonably possible.</p>			
Limited to: <ul style="list-style-type: none"> • 150 days per year in a Skilled Nursing Facility. • 60 days per year in an Inpatient Rehabilitation Facility. 	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
26. Substance Use Disorder Services			

Prior Authorization Requirement

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

You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.

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

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

	<p>Network</p> <p><i>Inpatient</i></p> <p>100%</p>	Yes	Yes
	<p><i>Outpatient</i></p> <p>100% after you pay a Copayment per visit of \$40</p> <p>100% for Partial Hospitalization/ Intensive Outpatient Treatment</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
	<p>Non-Network</p> <p><i>Inpatient</i></p> <p>70%</p>	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Outpatient</i> 70%	Yes	Yes
	70% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
27. Surgery - Outpatient			

Prior Authorization Requirement

For Non-Network Benefits for diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization. For a scheduled service, please call to request prior authorization at least five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.

	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes
28. Temporomandibular Joint Services			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization Benefits will be reduced to 50% of Eligible Expenses.

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for temporomandibular joint services received during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for temporomandibular joint services during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for temporomandibular joint services received during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for temporomandibular joint services during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. 		
<p>29. Therapeutic Treatments - Outpatient</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services; dialysis intensity modulated radiation therapy and MR-guided focused ultrasound. Please call us to request prior authorization at least five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as is reasonably possible.</p>			
	<p>Network</p> <p>100%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 70%	Yes	Yes

30. Transplantation Services

Prior Authorization Requirement

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

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

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. For Emergency admissions, we must be notified as soon as is reasonably possible.

<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p>	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for transplantation services during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for transplantation services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for transplantation services during outpatient surgery will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>.
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	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p>
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<ul style="list-style-type: none"> • Benefits for transplantation services during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for transplantation services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for transplantation services during outpatient surgery will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
31. Urgent Care Center Services			
<p>In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<p>Network</p> <p>100% after you pay a Copayment of \$100 per visit</p>	<p>Yes</p>	<p>No</p>
	<p>Non-Network</p> <p>70%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
32. Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.	Network 100% after you pay a Copayment of \$20 per visit	Yes	No
	Non-Network 70%	Yes	Yes
33. Vision Examinations			
Limited to 1 exam every 12 months	Network 100% after you pay a Copayment of \$10 per visit	Yes	No
	Non-Network 70%	Yes	Yes
34. Wigs			
	Network 100%	Yes	Yes
	Non-Network 70%	Yes	Yes

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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Additional Benefits Required By Missouri of Federal Law

35. Autism Spectrum Disorder Treatment

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Autism Spectrum Disorder Treatment, you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admission).

You must also obtain prior authorization for Non-Network Benefits before receiving the following services: Psychiatric Care, Psychological Care and Habilitative or Rehabilitative Care, including Applied Behavior Analysis Therapy.

If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.

	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for Autism Spectrum Disorders treatment during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for therapeutic treatments for Autism Spectrum Disorders will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>. • Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under <i>Pharmaceutical Products - Outpatient</i> in this <i>Schedule of Benefits</i>.
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	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for Autism Spectrum Disorders treatment during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for therapeutic treatments for Autism
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Spectrum Disorders will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>.</p> <ul style="list-style-type: none"> Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under <i>Pharmaceutical Products - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
36. Chiropractic Services			
<p>Coinsurance for Covered Health Services provided within the scope of a chiropractor's licenses will not exceed 50% of the total cost of any single chiropractic service as defined by Missouri law.</p> <p>No visit limit applies and there is no prior authorization required.</p>	<p>Network</p> <p>50%</p>	<p>Yes</p>	<p>No</p>
	<p>Non-Network</p> <p>50%</p>	<p>Yes</p>	<p>No</p>
37. Dental Anesthesia and Facility Charges			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization. For scheduled services, please call to request prior authorization at least five business days before receiving dental anesthesia services or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses. You do not need to obtain prior authorization for Emergency Health Services. Instead, in an Emergency situation, notify us as soon as reasonably possible.</p>			
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. 		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<ul style="list-style-type: none"> • Benefits for dental anesthesia surgery received on an outpatient basis will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>. • Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under <i>Physician Fees for Surgical and Medical Services</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. • Benefits for dental anesthesia surgery received on an outpatient basis will be the same as found under <i>Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>. • Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under <i>Physician Fees for Surgical and Medical Services</i> in this <i>Schedule of Benefits</i>. 		
<p>38. Early Intervention Services</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits, you must obtain prior authorization. For scheduled services, please call to request prior authorization at least five business days before receiving Early Intervention Services or as soon as is reasonably possible. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under <i>Durable Medical Equipment</i> 		

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>in this <i>Schedule of Benefits</i>.</p> <ul style="list-style-type: none"> • Benefits for early intervention services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for early intervention services that are considered rehabilitation services will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under <i>Durable Medical Equipment</i> in this <i>Schedule of Benefits</i>. • Benefits for early intervention services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for early intervention services that are considered rehabilitation services will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>. 		
<p>39. Enteral Formulas and Low Protein Modified Food Products</p>			
	<p>Network</p> <p>100%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Non-Network</p> <p>70%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
40. Hearing Screening for Newborns			
	Network 100%	No	No
	Non-Network 70%	Yes	Yes
41. Human Leukocyte Testing			
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for laboratory tests related to human leukocyte testing will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. • Benefits for human leukocyte testing during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for laboratory tests related to human leukocyte testing will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. • Benefits for human leukocyte testing during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. 		
42. Lead Poisoning Testing			

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for lead poisoning testing during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for lead poisoning testing that are preventive in nature will be the same as found under <i>Preventive Care Services</i> in this <i>Schedule of Benefits</i>. • Benefits for lab, x-ray and diagnostic services related to lead poisoning will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for lead poisoning testing during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for lead poisoning testing that are preventive in nature will be the same as found under <i>Preventive Care Services</i> in this <i>Schedule of Benefits</i>. • Benefits for lab, x-ray and diagnostic services related to lead poisoning will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
<p>43. Osteoporosis Services</p>			
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for osteoporosis services that are preventive in nature will be the same as found 		

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>under <i>Preventive Care Services</i> in this <i>Schedule of Benefits</i>.</p> <ul style="list-style-type: none"> Benefits for lab, x-ray and diagnostic services related to osteoporosis services will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. Benefits for osteoporosis services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> Benefits for osteoporosis services that are preventive in nature will be the same as found under <i>Preventive Care Services</i> in this <i>Schedule of Benefits</i>. Benefits for lab, x-ray and diagnostic services related to osteoporosis services will be the same as found under <i>Lab, X-Ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. Benefits for osteoporosis services during a Physician's office visit will be the same as found under <i>Physician's Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. 		
<p>44. Private Duty Nursing</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>Prior authorization is required for Private Duty Nursing for Non-Network Benefits. You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Limited to 105 visits per year.</p>	<p>Network</p> <p>100%</p>	<p>Yes</p>	<p>Yes</p>

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

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 70%	Yes	Yes
45. Speech and Hearing Services			
	<p>Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for speech and hearing therapy related to rehabilitation will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>. • Benefits for speech and hearing services during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under <i>Lab, X-ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
	<p>Non-Network</p> <p>Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:</p> <ul style="list-style-type: none"> • Benefits for speech and hearing therapy related to rehabilitation will be the same as found under <i>Rehabilitation Services - Outpatient Therapy</i> in this <i>Schedule of Benefits</i>. • Benefits for speech and hearing services during a Physician’s office visit will be the same as found under <i>Physician’s Office Services - Sickness and Injury</i> in this <i>Schedule of Benefits</i>. • Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under <i>Lab, X-ray and Diagnostics - Outpatient</i> in this <i>Schedule of Benefits</i>. 		
46. Telehealth			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Network</p> <p>Depending upon the Covered Health Service provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i>.</p>		
	<p>Non-Network</p> <p>Depending upon the Covered Health Service provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i>.</p>		
<p>47. Vision Correction after Surgery</p>			
<p>Prior Authorization Requirement</p> <p>Prior authorization is required for Non-Network Benefits. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p>Network</p> <p>100%</p>	<p>Yes</p>	<p>Yes</p>
	<p>Non-Network</p> <p>70%</p>	<p>Yes</p>	<p>Yes</p>

Eligible Expenses

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

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

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

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - o 50% of *CMS* for the same or similar laboratory service.
 - o 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - o For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - o For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
 - o When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
 - ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

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

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

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

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

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through

common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

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

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

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

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

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

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement

policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. If you want to receive Network Benefits, it is your responsibility to verify that the provider you select is a Network provider for the Covered Health Services you are seeking and for the product in which you are enrolled. You can verify that your provider is a Network provider online on www.myuhc.com or *Customer Care* at the telephone number on your ID card. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products.

Referrals to Appropriate Providers

Please contact *Customer Care* at the number on your ID card to obtain information about referrals that may be required if:

- Our Network does not include a health care provider with the expertise to treat the medical condition of a Covered Person;
- A standing referral to a Specialist Physician is needed;
- Our Network does not include a Specialist Physician that a newly enrolled Covered Person with a life-threatening condition or disease or a degenerative and disabling condition of disease, that may require specialized medical care over a prolonged period of time;
- Our Network does not include a specialty care center that a newly enrolled Covered Person with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time.

Second Opinion

You may seek a second medical opinion or consultation from a participating health care provider in our Network. If you choose to seek a second medical opinion, and we do not have a health care provider of the same expertise to provide a second medical opinion or consultation, you should contact us at the telephone number on your ID card to obtain information about seeking a second medical opinion from a Non-Network provider at no greater cost than a Network provider.

Second Opinion When Newly Diagnosed with Cancer

You may seek a second medical opinion from a participating Specialist Physician in our Network for a newly diagnosed cancer if referred by an attending Primary Physician. The same Policy terms and conditions apply to the Specialist Physician's second medical opinion as apply to Policy terms and conditions for a Specialist Physician's first medical opinion.

Our Network's Hold Harmless Provision

Our Network's contracts contain the below provision in all participating provider contracts.

Provider agrees that in no event, including but not limited to nonpayment by United or Payer, insolvency of United or Payer, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Customer or a person acting on behalf of the Customer, other than United or Payer, for Covered Services provided pursuant to this Agreement. This Agreement shall not prohibit Provider from collecting any copayments, deductibles or coinsurance for which the Customer is responsible under the Benefit Plan, as specifically provided in the Benefit Plan (or other evidence of coverage), or fees for uncovered services delivered on a fee for service basis to a Customer. This Agreement shall not prohibit Provider and a Customer from agreeing to continue services solely at the expense of the Customer, as long as Provider has clearly informed the Customer that United and/or Payer may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedies including, but not limited to, collecting from any insurance carrier providing coverage to a Customer. This section shall (a) survive termination of this Agreement for any reason with respect to Covered Services rendered while this Agreement is in force, (b) be construed to be for the benefit of the Customers, (c) supersede any oral or written agreement between Provider and a Customer, or a person acting on a Customer's behalf, that requires the Customer to pay for such Covered Services, and (d) apply to all Covered Services rendered by Provider or other party with whom Provider has entered into an agreement to provide such Covered Services, while this Agreement is in force.

Our Network's Insolvency Provision

Our Network's contracts contain the below provision in all participating provider contracts.

In the event United becomes insolvent or ceases to operate, Provider will continue to provide Covered Services to Customers through the period for which a premium has been paid on behalf of the Customer or until the Customer's discharge from an inpatient facility, whichever time is greater. United or Payer shall pay Provider at the previously contracted rate for services provided to a Customer under this paragraph. Continuation of care under this provision shall be provided without liability of the Customer to Provider for any amounts owed for medical care other than expenses that are the Customer's financial responsibility, such as deductibles or copayment amounts, specified in the Customer's Benefit Plan or other contract between the Customer and United or Payer.

Our Network's Continuation of Care Following Termination of Network Provider Provision

Our Network's contracts contain the following provision in all participating provider contracts.

Upon termination of the Agreement for any reason other than United's insolvency, Provider shall continue care to Customers for a period of up to ninety (90) days where the continuation of care is determined by United to be medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy or life threatening illness. United or Payer will pay Provider for this care at the rates in the Agreement. Continuation of care under this provision shall be provided without liability of the Customer to Provider for any amounts owed for medical care other than expenses that are the Customer's financial responsibility, such as deductibles or copayment amounts, specified in the Customer's Benefit Plan or other contract between the Customer and United or Payer.

Designated Facilities and Other Providers

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

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Certificate of Coverage Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below, through the following changes to the *Certificate of Coverage (Certificate)*.

Section 6: Questions, Grievances and Appeals is modified by replacing *Initial Determinations* with the following:

Initial Determinations

For initial determinations, we shall make the determination within 36 hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, we shall notify the provider rendering the service by telephone within 24 hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the enrollee and the provider within two working days of making the initial certification.

In the case of an adverse determination, we shall notify the provider rendering the service by telephone within 24 hours of making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider within one working day of making the adverse determination.

If we authorize a health care service, we will not later retract its authorization after the services have been provided, or reduce payment for an item or service furnished due to this authorization unless:

- The authorization is based on a material misrepresentation or omission about the enrollee's health condition.
- The plan terminates before the services are provided.
- The enrollee's coverage under the plan terminates before services are provided.

Determinations for Emergency Services

Emergency services necessary to screen and stabilize a member do not require prior authorization. Emergency services are subject to any applicable Copayments and/or Coinsurance. When emergency services require immediate post evaluation or post stabilization services, we will provide an authorization decision within sixty minutes of receiving the request; if the authorization decision is not made within thirty minutes, services will be deemed approved.

UnitedHealthcare Insurance Company



President

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 5: Defined Terms for Pediatric Dental Services*.

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

UnitedHealthcare Insurance Company



President

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

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

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

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

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
- D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this Rider.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

Annual Deductible

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

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

Benefits

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

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

Benefit Description

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<i>Diagnostic Services - (Subject to payment of the Annual Deductible.)</i>		
<p><i>Intraoral Bitewing Radiographs (Bitewing X-ray)</i></p> <p>Limited to 2 series of films per 12 months.</p>	100%	100%
<p><i>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)</i></p> <p>Limited to 1 time per 36 months.</p>	100%	100%
<p><i>Periodic Oral Evaluation (Check up Exam)</i></p> <p>Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.</p>	100%	100%
<i>Preventive Services - (Subject to payment of the Annual Deductible.)</i>		
<p><i>Dental Prophylaxis (Cleanings)</i></p> <p>Limited to 2 times per 12 months.</p>	100%	100%
<p><i>Fluoride Treatments</i></p> <p>Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.</p>	100%	100%
<p><i>Sealants (Protective Coating)</i></p> <p>Limited to once per first or second permanent molar every 36 months.</p>	100%	100%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p><i>Space Maintainers (Spacers)</i></p> <p>Benefit includes all adjustments within 6 months of installation.</p>	100%	100%
<i>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery - (Subject to payment of the Annual Deductible.)</i>		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p>Multiple restorations on one surface will be treated as a single filling.</p>	80%	80%
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>For anterior (front) teeth only.</p>	80%	80%
<p><i>Endodontics (Root Canal Therapy)</i></p>	80%	80%
<p><i>Periodontal Surgery (Gum Surgery)</i></p> <p>Limited 1 quadrant or site per 36 months per surgical area.</p>	80%	80%
<p><i>Scaling and Root Planing (Deep Cleanings)</i></p> <p>Limited to 1 time per quadrant per 24 months.</p>	80%	80%
<p><i>Periodontal Maintenance (Gum Maintenance)</i></p> <p>Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.</p>	80%	80%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p><i>Simple Extractions (Simple tooth removal)</i></p> <p>Limited to 1 time per tooth per lifetime.</p>	80%	80%
<p><i>Oral Surgery, including Surgical Extraction</i></p>	80%	80%
<p><i>Adjunctive Services - (Subject to payment of the Annual Deductible.)</i></p>		
<p><i>General Services (including Emergency Treatment)</i></p> <p>Covered as a separate Benefit only if no other service was done during the visit other than X-rays.</p> <p>General anesthesia is covered when clinically necessary.</p> <p>Occlusal guard limited to 1 guard every 12 months.</p>	80%	80%
<p><i>Major Restorative Services - (Subject to payment of the Annual Deductible.)</i></p> <p>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.</p>		
<p><i>Inlays/Onlays/Crowns (Partial to Full Crowns)</i></p> <p>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.</p>	50%	50%
<p><i>Fixed Prosthetics (Bridges)</i></p> <p>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</p>	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p><i>Removable Prosthetics (Full or partial dentures)</i></p> <p>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</p>	50%	50%
<p><i>Relining and Rebasing Dentures</i></p> <p>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</p>	50%	50%
<p><i>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</i></p> <p>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.</p>	50%	50%
<i>Implants - (Subject to payment of the Annual Deductible.)</i>		
<p><i>Implant Placement</i></p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p><i>Implant Supported Prosthetics</i></p> <p>Limited to 1 time per 60 months.</p>	50%	50%
<p><i>Implant Maintenance Procedures</i></p> <p>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.</p> <p>Limited to 1 time per 60 months.</p>	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<i>Repair Implant Supported Prosthesis by Report</i> Limited to 1 time per 60 months.	50%	50%
<i>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium</i> Limited to 1 time per 60 months.	50%	50%
<i>Repair Implant Abutment by Support</i> Limited to 1 time per 60 months.	50%	50%
<i>Radiographic/Surgical Implant Index by Report</i> Limited to 1 time per 60 months.	50%	50%
<p>Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)</p> <p>Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.</p>		
<i>Orthodontic Services</i> 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.	50%	50%

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Covered Dental Services*, Benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

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

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

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

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area.

Necessary - Dental Services and supplies under this Rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - ◆ For treating a life threatening dental disease or condition.
 - ◆ Provided in a clinically controlled research setting.
 - ◆ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services*.

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

UnitedHealthcare Insurance Company



President

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Vision Care Services*. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Copayments at the time of service.

Network Benefits:

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

Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*. Any amount you pay in Copayments for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the *Schedule of Benefits*. Any amount you pay in Copayments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits*.

Benefit Description

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).

- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing - far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

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

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

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

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

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

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once every 12 months.	100% after a Copayment of \$10 . Not subject to payment of the Annual Deductible.	70% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Eyeglass Lenses</i>	Once every 12 months.		
<ul style="list-style-type: none"> • <i>Single Vision</i> 		<p>100% after a Copayment of \$25 .</p> <p>Not subject to payment of the Annual Deductible.</p>	70% of the billed charge.
<ul style="list-style-type: none"> • <i>Bifocal</i> 		<p>100% after a Copayment of \$25 .</p> <p>Not subject to payment of the Annual Deductible.</p>	70% of the billed charge.
<ul style="list-style-type: none"> • <i>Trifocal</i> 		<p>100% after a Copayment of \$25 .</p> <p>Not subject to payment of the Annual Deductible.</p>	70% of the billed charge.
<ul style="list-style-type: none"> • <i>Lenticular</i> 		<p>100% after a Copayment of \$25 .</p> <p>Not subject to payment of the Annual Deductible.</p>	70% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Eyeglass Frames	Once every 12 months.		
<ul style="list-style-type: none"> <i>Eyeglass frames with a retail cost up to \$130.</i> 		100% Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Eyeglass frames with a retail cost of \$130 - 160.</i> 		100% after a Copayment of \$15 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Eyeglass frames with a retail cost of \$160 - 200.</i> 		100% after a Copayment of \$30 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Eyeglass frames with a retail cost of \$200 - 250.</i> 		100% after a Copayment of \$50 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Eyeglass frames with a retail cost greater than \$250.</i> 		60% Not subject to payment of the Annual Deductible.	70% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Contact Lenses Fitting & Evaluation	Once every 12 months.	100% after a Copayment of \$25 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Covered Contact Lens Selection</i> 	Limited to a 12 month supply.	100% after a Copayment of \$25 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<ul style="list-style-type: none"> <i>Necessary Contact Lenses</i> 	Limited to a 12 month supply.	100% after a Copayment of \$25 . Not subject to payment of the Annual Deductible.	70% of the billed charge.
<p>Low Vision Services Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.</p>	Once every 24 months		
<ul style="list-style-type: none"> Low vision testing 		100% of billed charges	75% of billed charges
<ul style="list-style-type: none"> Low vision therapy 		75% of billed charges	75% of billed charges

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services*, Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate*.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Spectera Eyecare Networks Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

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

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

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

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

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services*.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

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

UnitedHealthcare Insurance Company



President

Introduction

Coverage Policies and Guidelines

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

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

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. If you are actively taking a Prescription Drug Product, we will notify you electronically, or in writing, upon your request, at least thirty days prior to any deletions, other than generic substitutions, in our Policy.

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

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

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

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

Limitation on Selection of Pharmacies

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

Rebates and Other Payments

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

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

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communication 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, at your discretion, to purchase the described product at a discount. Pharmaceutical manufacturers or other non- UnitedHealthcare entities may pay for and/or provide content for these communications. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced Benefit based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What to do if you have a Question or Grievance

If you have a question, grievance or appeal concerning pharmaceutical prescriptions, please refer to Section 6: Questions, Grievances and Appeals in the *Certificate of Coverage* for the steps to resolve the issue.

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Section 1: Benefits for Prescription Drug Products

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

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

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy including Prescription Drug Products for the treatment of Autism Spectrum Disorders.

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

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy including Prescription Drug Products for the treatment of Autism Spectrum Disorders.

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

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

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

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy including Prescription Drug Products for the treatment of Autism Spectrum Disorders.

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

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

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

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. This exclusion does not apply to immunizations administered in a Network, non-Network or a Designated Pharmacy.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.
18. 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 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 assigned to the highest Tier.)

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 comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any oral non-sedating antihistamine or antihistamine-decongestant combination.
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury except for Prescription Drug Products for enteral formulas prescribed for the treatment of phenylketonuria or any inherited disease of amino and organic acids.
24. Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
25. Prescription Drug Products when prescribed as sleep aids.
26. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
28. Prescription Drug Products used for conditions that have been treated by a Specialist Physician, but have not been prescribed by a Specialist Physician.
29. A Prescription Drug Product that contains marijuana, including medical marijuana.
30. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable *United States Pharmacopeia* category and class or applicable state benchmark plan category and class.
31. Dental products, including but not limited to prescription fluoride topicals.

Section 3: Defined Terms

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

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

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

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

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

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

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

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

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

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

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

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 Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. Specialty Prescription Drug Products include certain drugs for Infertility.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug

Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Section 4: Your Right to Request an Exclusion Exception

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

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.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

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

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

Benefits for Oral Chemotherapeutic Agents

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

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

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

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

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tiered drug.

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

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Deletion Notification

If you are actively taking a particular Prescription Drug Product, we will notify you electronically, or in writing, upon your request, at least thirty days prior to any deletions, other than generic substitutions, in our Policy.

Payment Information

Payment Term And Description	Amounts
<p>Copayment and Coinsurance</p>	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Copayment/Coinsurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You</p>	

Payment Term And Description	Amounts
may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Specialty Prescription Drug Products</p> <p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p> <p>If a Prescription Drug Product is prescribed in a single dosage amount for which the Prescription Drug Product is not manufactured in such single dosage amounts, you will only be required to pay one Copayment for the combination of dosages that equals the prescribed dosage per 31 day supply.</p> <p>When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills if: 1) the prescribing Physician authorizes the Prescription Order or Refill and; 2) we are notified of the early refill.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$300 per Prescription Order or Refill.</p> <p>Non-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$150 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$300 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<ul style="list-style-type: none"> A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>If a Prescription Drug Product is prescribed in a single dosage amount for which the Prescription Drug Product is not manufactured in such single dosage amounts, you will only be required to pay one Copayment for the combination of dosages that equals the prescribed dosage per 31 day supply.</p> <p>When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills if: 1) the prescribing Physician authorizes the Prescription Order or Refill and; 2) we are notified of the early refill.</p>	<p>Drug Charge after you pay a Copayment of \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$80 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Non-Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>If a Prescription Drug Product is prescribed in a single dosage amount for which the Prescription Drug Product is not manufactured in such single dosage</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$20 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$80 per Prescription Order or Refill.</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>amounts, you will only be required to pay one Copayment for the combination of dosages that equals the prescribed dosage per 31 day supply.</p> <p>When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills if: 1) the prescribing Physician authorizes the Prescription Order or Refill and; 2) we are notified of the early refill.</p>	
<p>Prescription Drug Products from a Mail Order Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. <p>You may be required to fill an initial Prescription Drug Product order and obtain 2 refills through a retail pharmacy prior to using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p> <p>When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills if: 1) the prescribing Physician authorizes the Prescription Order or Refill and; 2) we are notified of the early refill.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$125 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$200 per Prescription Order or Refill.</p>

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential benefits include the following:

Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday.

On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA, the Public Health Service Act, and the Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- In-Network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, 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*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (<http://www.dol.gov.ebsa/healthreform/> - click link for Consumer Assistance Programs)

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

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

Your request should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed 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 appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly 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.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: September 23, 2013

We¹ are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on your health plan website, such as www.myuhc.com or www.uhcwest.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 - ◆ 1. HIV/AIDS;
 - ◆ 2. Mental health;
 - ◆ 3. Genetic tests;
 - ◆ 4. Alcohol and drug abuse;
 - ◆ 5. Sexually transmitted diseases and reproductive health information; and
 - ◆ 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on the back of your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

We will not take any action against you for filing a complaint.

¹This Medical Information Privacy Notice applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of New York, Inc.; Physicians Health Choice of Texas, LLC; Preferred Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: September 23, 2013

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your health plan ID card or contact the UnitedHealth Group Customer Call Center at 866-633-2446.

²For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Medical Information Privacy Notice, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of

Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: June 30, 2013

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- Show the categories of health information that are subject to these more restrictive laws; and
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.

AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington*,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

