

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan 1968A

of

NantMedia Holdings, LLC dba California Times

Group Number: 920816

Effective Date: January 1, 2023

Table of Contents

Schedule of Benefits	1
How Do You Access Benefits?	4
Does Prior Authorization Apply?	6
Covered Health Care Services which Require Prior Authorization	6
Care Management	8
Special Note Regarding Medicare	8
What Will You Pay for Covered Health Care Services?	8
Additional Benefits Required By California Law	34
Allowed Amounts	38
Provider Network	40
Second Medical Opinion	41
Timely Access to Care	42
Designated Providers	42
Health Care Services from Out-of-Network Providers Paid as Network Benefits	43
Limitations on Selection of Providers	43
Certificate of Coverage	2
What Is the Certificate of Coverage?	2
Can This Certificate Change?	2
Other Information You Should Have	2
Introduction to Your Certificate	3
What Are Defined Terms?	3
How Do You Use This Document?	3
How Do You Contact Us?	3
Your Responsibilities	4
Enrollment and Required Contributions	4
Be Aware the Policy Does Not Pay for All Health Care Services	4
Decide What Services You Should Receive	4
Choose Your Physician	4
Obtain Prior Authorization	4
Pay Your Share	4
Pay the Cost of Excluded Services	5
Show Your ID Card	5
File Claims with Complete and Accurate Information	5
Use Your Prior Health Care Coverage	5
Our Responsibilities	6
Determine Benefits	6
Pay for Our Portion of the Cost of Covered Health Care Services	6
Pay Network Providers	6
Pay for Covered Health Care Services Provided by Out-of-Network Providers	6
Review and Determine Benefits in Accordance with our Reimbursement Policies	6
Offer Health Education Services to You	7
Certificate of Coverage Table of Contents	8
Section 1: Covered Health Care Services	9
When Are Benefits Available for Covered Health Care Services?	9
1. Acupuncture Services	9
2. Ambulance Services	10
3. Clinical Trials	10
4. Congenital Heart Disease (CHD) Surgeries	13
5. Dental Services - Accident Only	13
6. Diabetes Services	14

7. Diabetes Treatment	14
8. Durable Medical Equipment (DME), Orthotics and Supplies	14
9. Emergency Health Care Services - Outpatient	15
10. Gender Dysphoria	15
11. Habilitative Services	16
12. Hearing Aids	18
13. Home Health Care	18
14. Hospice Care	18
15. Hospital - Inpatient Stay	18
16. Lab, X-Ray and Diagnostic - Outpatient	19
17. Major Diagnostic and Imaging - Outpatient	19
18. Mental Health Care and Substance-Related and Addictive Disorders Services	19
19. Obesity - Weight Loss Surgery	21
20. Ostomy Supplies	21
21. Pharmaceutical Products - Outpatient	22
22. Physician Fees for Surgical and Medical Services	22
23. Physician's Office Services	22
24. Pregnancy - Maternity Services	23
25. Preventive Care Services	23
26. Prosthetic Devices	27
27. Reconstructive Procedures	27
28. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	28
29. Scopic Procedures - Outpatient Diagnostic and Therapeutic	29
30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	30
31. Surgery - Outpatient	30
32. Temporomandibular Joint (TMJ) Services	30
33. Therapeutic Treatments - Outpatient	31
34. Transplantation Services	32
35. Urgent Care Center Services	32
36. Virtual Visits	32
37. Vision Exams	33
38. Wigs	33
Additional Benefits Required By California Law	33
39. Breast Cancer Services	33
40. Dental Anesthesia Services	33
41. Mastectomy Services	33
42. Off-Label Drug Use and Experimental or Investigational Services	34
43. Osteoporosis Services	34
44. Phenylketonuria (PKU) Treatment	35
45. Prosthetic Devices - Laryngectomy	35
46. Telehealth Services	35
Section 2: Exclusions and Limitations	36
How Do We Use Headings in this Section?	36
We Do Not Pay Benefits for Exclusions	36
Where Are Benefit Limitations Shown?	36
A. Alternative Treatments	36
B. Dental	37
C. Devices, Appliances and Prosthetics	37
D. Drugs	38
E. Experimental or Investigational or Unproven Services	39
F. Foot Care	39
G. Medical Supplies and Equipment	40
H. Mental Health Care and Substance-Related and Addictive Disorders	40
I. Nutrition	41
J. Personal Care, Comfort or Convenience	41

K. Physical Appearance	42
L. Procedures and Treatments	43
M. Providers	43
N. Reproduction.....	44
O. Services Provided under another Plan	44
P. Transplants	44
Q. Travel.....	44
R. Types of Care	45
S. Vision and Hearing.....	45
T. All Other Exclusions	45
Section 3: When Coverage Begins	47
How Do You Enroll?	47
What If You Are Hospitalized When Your Coverage Begins?.....	47
What If You Are Eligible for Medicare?	47
Who Is Eligible for Coverage?	47
Eligible Person.....	47
Dependent	47
When Do You Enroll and When Does Coverage Begin?	48
Initial Enrollment Period.....	48
Open Enrollment Period	48
New Eligible Persons.....	48
Adding New Dependents.....	48
Special Enrollment Period	48
Section 4: When Coverage Ends	51
General Information about When Coverage Ends	51
What Events End Your Coverage?	51
Fraud or Intentional Misrepresentation of a Material Fact.....	52
Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage	52
Coverage for a Disabled Dependent Child.....	52
Extended Coverage for Total Disability	53
Continuation of Coverage.....	53
Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage	54
Section 5: How to File a Claim	55
How Are Covered Health Care Services from Network Providers Paid?	55
How Are Covered Health Care Services from an Out-of-Network Provider Paid?	55
Payment of Benefits	56
Section 6: Questions, Complaints and Appeals	57
IMPORTANT NOTICE - CLAIM DISPUTES	57
IMPORTANT NOTICE - NETWORK PROVIDER ACCESSIBILITY COMPLAINTS.....	57
What if You Have a Question?	58
What if You Have a Complaint?	58
What to Do if You Disagree with Our Adverse Benefit Determination	58
Post-service Claims.....	58
Pre-service Requests for Benefits.....	58
How to Request an Appeal.....	58
Appeal Process	59
Appeals Determinations	59
Pre-service Requests for Benefits and Post-service Claim Appeals	59
Non-Urgent Pre-Service Requests Based on Medical Necessity	59
Concurrent Care Claims.....	60
Urgent Appeals that Require Immediate Action	60
Denial of Experimental, Investigational or Unproven Services	61

Independent External Review Program.....	61
Section 7: Coordination of Benefits	63
Benefits When You Have Coverage under More than One Plan	63
When Does Coordination of Benefits Apply?	63
Definitions	63
What Are the Rules for Determining the Order of Benefit Payments?	65
Effect on the Benefits of This Plan	66
Right to Receive and Release Needed Information	67
Payments Made.....	68
Does This Plan Have the Right of Recovery?	68
How Are Benefits Paid When This Plan is Secondary to Medicare?	68
Section 8: General Legal Provisions	69
What Is Your Relationship with Us?	69
What Is Our Relationship with Providers and Groups?	69
What Is Your Relationship with Providers and Groups?	70
Notice.....	70
Statements by Group or Subscriber	70
Do We Pay Incentives to Providers?	71
Are Incentives Available to You?	71
Who Interprets Benefits and Other Provisions under the Policy?	71
Who Provides Administrative Services?	71
Amendments to the Policy	72
How Do We Use Information and Records?	72
Do We Require Examination of Covered Persons?	73
Is Workers' Compensation Affected?	73
How Are Benefits Paid When You Are Medicare Eligible?	73
Reimbursement - Right to Recovery	73
When Do We Receive Refunds of Overpayments?	74
Change of Beneficiary	75
Non-Discrimination in Contract Availability or Terms	75
Legal Actions	75
What Is the Entire Policy?	75
Section 9: Defined Terms	76
Section 10: Patient Protection and Affordable Care Act (PPACA) Zero	
Cost Share Preventive Care Medications.....	91
Benefits for PPACA Zero Cost Share Preventive Care Medications	91
Identification Card (ID Card) - Network Pharmacy	91
Designated Pharmacies	91
Rebates and Other Payments	91
How Do Supply Limits Apply?	92
Defined Terms	92
Clinical Trials	1
Allowed Amounts.....	1
Gender Dysphoria	1
Mental Health Care and Substance-Related and Addictive Disorders Services.....	2
What Will You Pay for Covered Health Care Services?.....	6
ACCESS TO A NETWORK PROVIDER:	7
If medically appropriate care from a qualified provider cannot be provided within the network, we will arrange for the required care with an available and accessible Out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.	7
Timely Access To Care	7
Preventive Care Services	1

Amendments, Riders and Notices (As Applicable)

Clinical Trials Amendment

Emergency Air Ambulance Services Amendment

Continuity of Care for Maternal Mental Health Condition Amendment

Mental Health Care and Substance-Related and Addictive Disorders

Services Amendment

Preventive Care Services Amendment

Telehealth Services Amendment

Consolidated Appropriations Act Amendment

Home Test Kits for Sexually Transmitted Diseases Amendment

Right to Request Confidential Communications Related to Sensitive

Services Amendment

Outpatient Prescription Drug Rider

Zero Cost Share Medications Addendum

UnitedHealthcare Insurance Company

Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

Expatriate Insurance Rider

Vision Materials Rider

Fertility Preservation for Iatrogenic Infertility Rider

Real Appeal Rider

Language Assistance Services

Notice of Non-Discrimination

Important Notices

Statement of Employee Retirement Income Security Act of 1974

(ERISA) Rights

ERISA Statement

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are restricted to Covered Health Care Services provided by Network providers for the following: Infertility Services; Obesity - Weight Loss Surgery; Preventive Care Services; Rehabilitation Services - Outpatient Therapy and Transplantation Services. This limitation does not apply to Emergency Health Care Services.

Enrolled Dependents who do not reside with the Subscriber and live outside the Service Area must see a Network provider in order to obtain Benefits for the Covered Health Care Services listed above.

Benefits are available from both Network providers and out-of-Network providers except as listed above. Covered Health Care Services are payable at a higher Benefit level from Network providers, and Covered Health Care Services obtained from out-of-Network providers are payable at a lower Benefit level.

DIRECTORY OF NETWORK PROVIDERS

The current directory of Network providers is available online at www.myuhc.com. You may obtain a paper copy of the network provider directory at no cost by contacting us at the telephone number on your ID card.

AVAILABILITY OF TELEPHONE TRIAGE OR SCREENING SERVICES

Triage or screening services are the assessment of your health concerns and symptoms through communication, with a Physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or Triage your need for care for the purpose of determining the urgency of your need for medical services. To access Triage or screening services you should contact Customer Care during normal business hours at the telephone number on your ID card.

In addition to accessing *Customer Care*, you are able to access a registered nurse at Optum's Nurseline, 24 hours per day, 7 days per week by contacting the myNurseline phone number on the back of your ID card or by visiting www.myuhc.com. Once logged into the myuhc.com portal, the *Ask a Nurse*

option will be available, and you may chat online or use the phone number provided to you to speak to a nurse. Optum's Nurseline can help you:

- Chat with a nurse live on myuhc.com.
- Understand treatment options.
- Ask medication questions.
- Choose appropriate medical care.
- Locate available local resources.
- Find a Physician, Hospital or specialist.

Although Triage or screening services are available 24 hours per day, 7 days per week, it is not intended to replace or interfere with normal Physician/patient communication.

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

You may contact us or the California Department of Insurance if you have a complaint regarding your ability to access needed health care in a timely manner as described in *IMPORTANT NOTICE - Network Provider Accessibility Complaints* in the *Certificate of Coverage* under *Section 6: Questions, Complaints and Appeals*. Before contacting the California Department of Insurance, please contact us to discuss your complaint.

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357)

1-800-482-4833 (TTY)

You may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Internet Web site: <http://www.insurance.ca.gov>

ACCESS TO A NETWORK PROVIDER:

If medically appropriate care from a qualified provider cannot be provided within the network, we will arrange for the required care with an available and accessible Out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

Timely Access To Care

The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your Physician can request that the appointment be sooner.

Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.

In-person appointment wait times:

Urgent Appointments	Wait time
For services that don't need prior authorization	48 hours
For services that do need prior authorization	96 hours
Non-Urgent Appointments	Wait time
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat an injury, illness or other health condition	15 business days

Telephone wait times:

You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your ID card.

If you call the number at the back of your ID card, someone should answer the phone within 10 minutes during normal business hours.

Important Language Information:

You may be entitled to the right and services below. These rights apply only under California law. These rights do not apply to all languages.

You can get an interpreter to help you talk with your Physician or to us. To get help in your language, please call us at:

UnitedHealthcare Insurance Company 1-800-624-8822 / TTY: 711

Language services are at no cost to you. Written information may be available in some languages. If you need more help, call 1-800-927-HELP (1-800-927-4357) or 1-800-482-4833 (TTY). Internet website: <http://www.insurance.ca.gov>.

ANNUAL DEDUCTIBLE AND OUT-OF-POCKET LIMIT

You will have to meet a higher Annual Deductible and Out-of-Pocket Limit when an out-of-Network provider is chosen to provide Covered Health Care Services.

How Do You Access Benefits?

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

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

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

Emergency Health Care Services are always paid as Network Benefits.

For facility charges, these are Benefits for Covered Health Care Services that are billed by a Network facility and provided under the direction of either a Network or out-of-Network Physician or other provider. Benefits for non-Emergency Covered Health Care Services include Physician services provided in a Network facility by a Network or an out-of-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

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

- **Emergency Health Care Services provided by an out-of-Network provider** - Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described in this *Schedule of Benefits*. **California Insurance Code §10112.7 requires a health insurer to cover Emergency Health Care Services in an emergency department of a Hospital without the need for prior authorization, regardless of whether the provider is a Network Provider under the plan, and subject to the same cost sharing required if the services were provided by Network Provider. You will not pay more than the Network cost sharing amount.**
- **Covered Health Care Services that are NOT Emergency Health Care Services provided by an out-of-Network provider that is not chosen by you** - Covered Health Care Services that are provided at a Network facility by an out-of-Network facility based Physician, or as a result of receiving services in a contracting facility, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in this *Schedule of Benefits*. **You will not pay more than the Network cost sharing amount. The Network cost sharing amount means the same cost sharing that you would pay for the same Covered Health Care Services if they were received from a contracting individual health professional. Additionally the Network deductible and Out-of-Pocket Limit apply for Covered Health Care Services rendered by an out-of-Network provider in a Network contracting health facility, or as a result of receiving services in a contracting facility, including a hospital, ambulatory surgery or other outpatient setting, laboratory and radiology or imaging center. When you receive Covered Health Care Services from a Network facility and as a result of which, you receive additional Covered Health Care Services from an out-of-Network individual health professional, you will not pay more than the Network cost sharing amount.**

- **Covered Health Care Services provided by an out-of-Network provider that are NOT Emergency Health Care Services from an out-of-Network facility based Physician that you have chosen** - Covered Health Care Services that are provided at a Network facility by an Out-of-Network facility based Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in this *Schedule of Benefits*. **As a result, you may be responsible for the difference between the amount billed by the out-of-Network facility based Physician and the reimbursement amount that is an Allowed Amount. The payments you make to out-of-Network facility based Physicians for charges above the Allowed Amounts do not apply towards any applicable Out-of-Pocket Limit.**

An out-of-Network facility based Physician may bill or collect the out-of-network cost sharing from you, if applicable, only when you consent in writing and that written consent demonstrates satisfaction of all the following criteria:

- At least 24 hours in advance of care, you consent in writing to receive Covered Health Care Services from the identified out-of-Network facility based Physician.
- The consent must be obtained by the out-of-Network facility based Physician in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent cannot be obtained by the facility or any representative of the facility. The consent cannot be obtained at the time of admission or at any time when you are being prepared for surgery or any other procedure.
- At the time consent is provided, the out-of-Network facility based Physician must give you a written estimate of your total out-of-pocket cost of care. The written estimate must be based on the out-of-Network based Physician's billed charges for the Covered Health Service to be provided. The out-of-Network facility based Physician cannot attempt to collect more than the estimated amount without receiving separate written consent from you or your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the out-of-Network facility based Physician to change the estimate.
- The consent must advise you that you may elect to seek care from a Network provider or may contact us in order to arrange to receive the Covered Health Care Service from a Network provider for lower out-of-pocket costs.
- The consent and estimate must be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the California Health and Safety Code.
- The consent must advise you that any costs incurred as a result of your use of the out-of-Network Benefit must be in addition to the Network cost-sharing amounts and may not count toward the annual Out-of-Pocket Limit on Network Benefits or a deductible, if any, for Network benefits.

If you disagree with an Allowed Amounts determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the *Certificate of Coverage*. You may also call us at the telephone number on your ID card.

Note: This plan covers up to a 12-month supply of *FDA*-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

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

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

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

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

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. 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 shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

You do not need a referral to obtain Covered Health Care Services for women's reproductive and sexual health care services. Reproductive and sexual healthcare services include the following:

- Prevention or treatment of pregnancy.
- Prevention, diagnosis and treatment of an infectious, communicable or sexually transmitted disease, including HIV.
- Abortion.
- Treatment of rape or sexual assault, including medical care related to the diagnosis or treatment of the conditions and collection of medical evidence.

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

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

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

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

Covered Health Care 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 find out how far in advance you must obtain prior authorization.

- Ambulance - non-emergent air and ground.
- Breast cancer services.
- Breast pumps.
- Clinical trials.
- Congenital heart disease surgery.
- Diabetes treatment.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Genetic Testing.
- Habilitative Services - physical therapy, occupational therapy, Manipulative Treatment, speech therapy, post-cochlear implant aural therapy, and cognitive therapy.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or exceeding 96 hours for a cesarean section delivery. Initial maternity stays up to 48 hours for vaginal delivery and up to 96 hours for a cesarean delivery are exempt from prior authorization. Prior authorization is not required for Emergency admissions.
- Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.
- Major Diagnostics - Outpatient - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.
- Mastectomy services.
- Mental Health Care and Substance Related and Addictive Disorders Services - inpatient services (including services at a Residential Treatment facility). Prior authorization only applies to non-Emergency inpatient admissions.
- Obesity - weight loss surgery.
- Pain management.
- Prosthetic devices over \$1,000 in cost per device.
- Prosthetic devices incident to a laryngectomy.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.

- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

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

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

If you choose to receive a service that is not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid. If you have a question regarding a determination of whether a service is Medically Necessary, call the telephone number on your ID card. If you disagree with a determination of whether a service is Medically Necessary, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the *Certificate of Coverage*. You may also call the telephone number on your ID card.

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per	Network

Payment Term And Description	Amounts
<p>year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are calculated appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>\$1,000 per Covered Person, not to exceed \$3,000 for all Covered Persons in a family.</p> <p>An individual's payment toward the Annual Deductible is limited to the \$1,000 per Covered Person Annual Deductible amount stated above.</p> <p>Out-of-Network</p> <p>\$2,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>An individual's payment toward the Annual Deductible is limited to the \$2,000 per Covered Person Annual Deductible amount stated above.</p>
<p>Out-of-Pocket Limit</p>	
<p>The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Allowed Amounts are calculated appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Limit excludes Premiums, balance billing amounts for out-of-Network providers and your spending for non-covered services.</p>	<p>Network</p> <p>\$2,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>An individual's payment toward the Out-of-Pocket Limit is limited to the \$2,000 per Covered Person Out-of-Pocket Limit amount stated above. After an individual meets this Out-of-Pocket Limit amount, the Covered Person is no longer responsible for cost sharing for the rest of the year.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p> <p>Out-of-Network</p> <p>\$3,000 per Covered Person not to exceed \$9,000 for all Covered Persons in a family.</p> <p>An individual's payment toward the Out-of-Pocket Limit is limited to the \$3,000 per Covered Person Out-of-Pocket Limit amount stated above. After an individual meets this Out-of-Pocket Limit amount, the Covered Person is no longer responsible for cost sharing for the rest of the year.</p> <p>Allowed amounts for out-of-Network</p>

Payment Term And Description	Amounts
	<p>Emergency Health Care Services accrue to the Network Out-of-Pocket Limit. Emergency Health Care Services include expenses for the emergency facility, professional services and emergency medical transportation.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p>
Co-payment	
<p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount. <p>Details about the way in which Allowed Amounts are calculated appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Co-insurance	
<p>Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are calculated appear at the end of the <i>Schedule of Benefits</i> table.</p>	

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	10%	Yes	Yes
	Out-of-Network		
	<i>Ground Ambulance</i>	30%	Yes
	<i>Air Ambulance</i>	30%	Yes

3. Clinical Trials

Prior Authorization Requirement

You must obtain prior authorization as soon as reasonably possible if participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

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

Network

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

Out-of-Network

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

4. Congenital Heart Disease (CHD) Surgeries

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon reasonably possible if a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization as required, you

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
will incur a penalty of \$1000 per surgery.			
Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	Network 10%	Yes	Yes
	Out-of-Network 30%		
5. Dental Services - Accident Only			
	Network 10%	Yes	Yes
	Out-of-Network Same as Network		
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
7. Diabetes Treatment			
<p>Prior Authorization Requirement</p> <p>Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
<p>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</p> <p>Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.</p>	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>transfer is medically appropriate. Network Benefits will not be stopped until after you are stabilized and the care no longer constitutes Emergency Health Care Services as defined in the Policy.</p>	<p>inpatient to a Hospital directly from the Emergency room you will not have to pay this Co-payment. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p> <p>Out-of-Network</p> <p>Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
10. Gender Dysphoria			
<p><i>Outpatient Office Visits include:</i></p> <ul style="list-style-type: none"> Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, cross-sex hormone therapy and medication management. <p><i>All Other Outpatient Office Visits include but not limited to:</i></p> <ul style="list-style-type: none"> Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral Health Treatment for pervasive 	<p>Network</p> <p><i>Inpatient</i></p> <p>10%</p> <p><i>Outpatient Office Visits</i></p> <p>\$20 per visit</p> <p><i>All Other Outpatient Office Visits</i></p> <p>10%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>No</p> <p>Yes</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>developmental disorder or Autism Spectrum Disorders delivered at home, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.</p> <p>Outpatient prescription drugs for the treatment of gender dysphoria are subject to the cost share as noted in the <i>Outpatient Prescription Drug Schedule of Benefits</i>.</p>	<p>Out-of-Network</p> <p><i>Inpatient</i> 30%</p> <p><i>Outpatient Office Visits</i> 30%</p> <p><i>All Other Outpatient Office Visits</i> 30%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>
<p>11. Habilitative Services</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1000 per admission.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p>			
<p>Inpatient services limited per year as follows:</p>	<p>Network</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>Limit will be the same as, and combined with, those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i>.</p> <p>Outpatient therapies:</p> <ul style="list-style-type: none"> • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. <p>For the above outpatient therapies:</p> <p>Limits will be the same as, and combined with, those stated under <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>.</p>	<p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Outpatient</i></p> <p>\$20 per visit</p>	<p>Yes</p>	<p>No</p>
<p>12. Hearing Aids</p>	<p>Network</p>		
<p>Limited to \$5,000 every year. Benefits</p>	<p>Network</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

13. Home Health Care

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per visit.

Limited to 120 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. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

14. Hospice Care

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>authorization as required, you will incur a penalty of \$1,000 per Inpatient Stay in a hospice facility.</p> <p>In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>			
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
15. Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p>			
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
16. Lab, X-Ray and Diagnostic - Outpatient			
<p align="center">Prior Authorization Requirement</p>			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 30%	Yes	Yes
18. Mental Health Care and Substance-Related and Addictive Disorders Services	<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions).</p> <p>If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p>		
<p><i>Outpatient Office Visits</i> include:</p> <ul style="list-style-type: none"> Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, medication management, office-based medication-assisted opioid treatment, including methadone and treatment programs at federally qualified methadone clinics. <p><i>All Other Outpatient Office Visits</i> include but not limited to:</p> <ul style="list-style-type: none"> Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric 	<p>Network</p> <p><i>Inpatient</i></p> <p>10%</p> <p><i>Outpatient Office Visits</i></p> <p>\$20 per visit</p> <p><i>All Other Outpatient Office Visits</i></p> <p>10%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>No</p> <p>Yes</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders delivered at home, medication-assisted opioid treatment programs including methadone provided as part of or separate (stand-alone program) from a facility-based treatment program, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.</p>	<p><i>Out-of-Network</i></p> <p><i>Inpatient</i> 30%</p> <p><i>Outpatient Office Visits</i> 30%</p> <p><i>All Other Outpatient Office Visits</i> 30%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>

19. Obesity - Weight Loss Surgery

Prior Authorization Requirement

You must obtain prior authorization as soon as reasonably possible if obesity - weight loss surgery

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>arises. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per surgery.</p> <p>It is important that you notify us regarding your intention to have surgery; however, prior notification is not required. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you. These programs are in addition to the Benefits available for Obesity - Weight Loss Surgery. You may call <i>Customer Care</i> at the telephone number on your ID card for information regarding these programs</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Out-of-Network Benefits are not available.</p>		
20. Ostomy Supplies			
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
21. Pharmaceutical Products - Outpatient			
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p>	<p>Yes</p>	<p>Yes</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	30%	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
	Network 10% Out-of-Network 30%	Yes Yes	Yes Yes
23. Physician's Office Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing is performed. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per Genetic test.			
In addition to the office visit Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic 	Network \$20 per visit for a Primary Care Physician office visit or \$40 per visit for a Specialist office visit	Yes	No

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.</p> <ul style="list-style-type: none"> • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<p>Out-of-Network</p> <p>30%</p>	<p>Yes</p>	<p>Yes</p>

24. Pregnancy - Maternity Services

We encourage you to notify us regarding your Pregnancy; however, prior notification is not required. 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. These programs are in addition to prenatal and other maternity benefits that are available to you. You may call *Customer Care* at the telephone number on your ID card for information regarding these programs.

Prior Authorization Requirement

For outpatient maternity services, you may receive obstetrical and gynecological Covered Health Care Services directly from a Physician without a referral or seeking prior authorization.

For Inpatient Stays for delivery, you may receive maternity service, including labor and delivery without a referral or seeking prior authorization.

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per Inpatient Stay of 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

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
cesarean section delivery.			
<p>We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.</p> <p>All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care Act, will be provided without cost share. Please refer to Preventive Care Services below.</p>	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of your pregnancy.</p> <p>Out-of-Network</p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>		
25. Preventive Care Services	Prior Authorization Requirement		
<p>For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per breast pump.</p>			
	<p>Network</p> <p>None</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
26. Prosthetic Devices	Prior Authorization Requirement		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
	<p>Network 10%</p> <p>Out-of-Network 30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<p>27. Reconstructive Procedures</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per scheduled and/or non-scheduled procedures.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per scheduled and/or non-scheduled procedures.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>Out-of-Network</p> <p>30%</p>	Yes	Yes
<p>30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>	<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days or as soon as reasonably possible before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (excluding Emergency admissions). If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per admission.</p>		
<p>Limited to 120 days per year.</p>	<p>Network</p> <p>10%</p>	Yes	Yes
	<p>Out-of-Network</p> <p>30%</p>	Yes	Yes
<p>31. Surgery - Outpatient</p>	<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per scheduled and/or non-scheduled services.</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>

32. Temporomandibular Joint (TMJ) Services

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per Inpatient Stay.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per Inpatient Stay.

Covered Health Care Services are payable in the same manner as surgery for other medical conditions.

Network

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

Out-of-Network

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

33. Therapeutic Treatments - Outpatient

Prior Authorization Requirement

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, you will incur a penalty of \$1,000 per service.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
34. Transplantation Services			
Prior Authorization Requirement			
For Network Benefits you must obtain prior authorization as soon as is reasonably possible before a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). You must receive transplantation services from a Designated Provider. If you don't obtain prior authorization and do not use a Designated Provider, Network Benefits will not be paid.			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits. Please see the provision for Designated Providers below, for additional information regarding the use of a Designated Provider.	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Out-of-Network Benefits are not available.		
35. Urgent Care Center Services			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<p>Network \$50 per visit</p> <p>Out-of-Network 30%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
36. Virtual Visits			
<p>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at</p>	<p>Network None</p>	<p>Yes</p>	<p>No</p>

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
www.myuhc.com or the telephone number on your ID card.	<p>Out-of-Network</p> <p>Out-of-Network Benefits are not available.</p>	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
37. Vision Exams			
Limited to 1 exam every year.	<p>Network</p> <p>\$20 per visit</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
38. Wigs			
Limited to \$600 every 24 months.	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
Additional Benefits Required By California Law			
39. Breast Cancer Services			
<p align="center">Prior Authorization Requirement</p> <p align="center">Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
	Network		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
40. Dental Anesthesia Services			
<p>Services are limited to Covered Persons who are one of the following:</p> <ul style="list-style-type: none"> • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age. 	<p>Network</p> <p>10%</p> <p>Out-of-Network</p> <p>30%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
41. Mastectomy Services			
<p>Prior Authorization Requirement</p> <p>Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p>provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
<p>42. Off-Label Drug Use and Experimental or Investigational Services</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
<p>43. Osteoporosis Services</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
44. Phenylketonuria (PKU) Treatment			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining formulas or special food products for the management and treatment of Phenylketonuria (PKU). If you fail to obtain prior authorization as required, you will incur a penalty of \$1,000 per treatment.			
	Network 10% Out-of-Network 30%	Yes Yes	Yes Yes
45. Prosthetic Devices - Laryngectomy			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule</i>		

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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

Allowed Amounts

Benefits for Covered Health Care Services are based on Allowed Amounts. Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network facility based Physician (other than Emergency Health Care Services or services otherwise arranged by us), you will be responsible to the out-of-Network facility based Physician for any amount billed that is greater than the amount we calculate to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are calculated in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or an

amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are calculated, based on:
 - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Allowed Amounts are calculated 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:
 - ▶ 50% of *CMS* for the same or similar laboratory service.
 - ▶ 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - ▶ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
 - ▶ When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
 - ▶ When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

IMPORTANT NOTICE: Out-of-Network providers at a Network facility may not bill you for any difference between the provider's billed charges and the Allowed Amount described here.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or 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 medically appropriate care from a qualified provider cannot be provided within the Network, we will arrange for the required care with an available and accessible out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

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

Continuity of Care

If you are undergoing a course of treatment with a Network provider for one of the medical conditions below, and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's agreement, for continuation of Covered Health Care Services rendered by the terminated provider for the time periods shown below. Co-payments, deductibles or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

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

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a health condition or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Health Care Services will be provided for the duration of the acute condition.
- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, health condition, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health Care Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, in consultation with you and the terminated Network provider and consistent with good

professional practice. Completion of Covered Health Care Services under this provision will not exceed 12 months from termination date of the provider's agreement.

- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Care Services will be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Care Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement.
- **The care of a newborn child between birth and age 36 months.** Completion of Covered Health Care Services will not exceed 12 months from the termination date of the provider's agreement.
- **Performance of a surgery or other procedure.** Performance of a surgery or other procedure that has been recommended and documented by the Network provider to occur within 180 days of the termination date of the provider's agreement.

This section does not apply to treatment by a provider or provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

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

Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician or appropriately qualified health care professional. When a second opinion is requested by you or by a Network Physician or health professional that is treating you, we will authorize a second opinion by an appropriately qualified health care professional. The Physician or appropriately qualified health care professional acting within his or her scope of practice, must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment (including, but not limited to, a chronic condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Physician is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the initial treating Physician and still have serious concerns about the diagnosis or treatment.

In most cases, you or your treating Physician or health care professional will request a second medical opinion without consulting us. However, in the event that we approve a request by you for a second medical opinion, you shall be responsible only for the costs of applicable Co-payments that are required for similar referrals.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Physician or health care professional. It will include any recommended procedures or tests that the Physician or health care professional giving the second opinion believes are appropriate.

Please Note: The fact that an appropriately qualified Physician or health care professional gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is medically necessary or a Covered Health Care Service. If the recommended action is not Medically Necessary or is not a Covered Health Care Service, you will also remain responsible for paying any appropriate fees to the Physician or health care professional that performs that recommended action.

Timely Access to Care

Appointment wait times are as follows:

- Emergency Health Care Services are available and accessible within the plan's service area 24 hours, 7 days a week. Ambulance services for the service area served by the plan to transport you to the nearest 24-hour facility with Physician coverage.
- Urgent health care services that do not require prior authorization are offered within 48 hours of the request. Urgent health care services that require prior authorization are offered within 96 hours of the request.
- Non-urgent care primary care and non-urgent, non-Physician Mental Health Care Services are offered within 10 business days of the request.
- Non-urgent specialist care and ancillary services are offered within 15 business days of the request.
- Interpreter services will be coordinated with scheduled appointments for Covered Health Care Services in a manner that ensures the provision of interpreter services at the time of the appointment.

Designated Providers

If you have a medical condition that needs special services, we may direct you to a Designated Provider. Medical conditions that may require special services include medical conditions that require transplantation services. Case management would enable the member to be directed to the appropriate facility/Physician to maximize care. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

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

You or your Network Physician must notify us of special service needs (such as transplants) that might warrant referral to a Designated Provider. Regardless of the Network status of the provider (Designated Provider, Network provider or out-of-Network provider), failure to provide advance notification will result in you being responsible for paying all charges and no Benefits will be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available or accessible from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available or accessible from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

If you disagree with a Benefit determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the *Certificate of Coverage*. You may also call the telephone number on your ID card.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

IMPORTANT NOTICE: This Policy restricts certain Benefits to Covered Health Care Services provided by Network providers only. A complete notice that lists the Benefits subject to this restriction is included in the Schedule of Benefits.

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TTY: 1-800-482-4833

<http://www.insurance.ca.gov>

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. If there are material changes in any of the terms of the Policy, UnitedHealthcare will provide sixty (60) days advance notice to the Group. The Group shall be responsible for delivering the notice to all Covered Persons and to other persons eligible for coverage.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

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

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in California. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, California law governs the Policy.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. 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 Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. Please review *Section 5: How to File a Claim* to become familiar with how to request payment from us for Covered Health Care Services you receive from an out-of-Network provider.

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

Our administrative function regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received is based on this contract and is subject to the other terms, limitations and exclusions set out in this *Certificate* and *Schedule of Benefits*. 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 will do the following:

- Pay Benefits according to this Policy and subject to 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.

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

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent review, is described under *Section 6: Questions, Complaints and Appeals*. You may also call the telephone number listed on your identification (ID) card.

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.

- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Offer Health Education Services to You

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

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services	9
Section 2: Exclusions and Limitations.....	36
Section 3: When Coverage Begins	47
Section 4: When Coverage Ends	51
Section 5: How to File a Claim	55
Section 6: Questions, Complaints and Appeals	57
Section 7: Coordination of Benefits	63
Section 8: General Legal Provisions	69
Section 9: Defined Terms	76
Section 10: Patient Protection and Affordable Care Act (PPACA) Zero Cost Share Preventive Care Medications.....	91

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

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

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit). Allowed amounts for out-of-Network Emergency Health Care Services accrue to the Network Out-of-Pocket Limit. Emergency Health Care Services include expenses for the emergency facility, professional services and emergency medical transportation.
- 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. Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or

- Certified by a national accrediting body.

2. Ambulance Services

Emergency:

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Care Services can be performed. Benefits for emergency ambulance transportation are available and do not require prior authorization in the following situations:

- A reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance services.
- The treating Physician determines that you must be transported to another facility because the Emergency medical condition is not stabilized and the care you require is not available at the treating facility.
- For purposes of this Benefit, "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by you to result in any of the following:
 - placing your health in serious jeopardy;
 - serious impairment to bodily functions;
 - serious dysfunction of any bodily organ or part;
 - active labor, meaning labor at a time that either of the following would occur:
 - there is inadequate time to effect safe transfer to another Hospital prior to delivery, or
 - a transfer poses a threat to the health and safety of your or your unborn child.

An Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders you as being either of the following:

- An immediate danger to yourself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Non-Emergency:

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) and psychiatric transport van services when the vehicle transports you to or from the Covered Health Care Services and the use of other means of transportation may endanger your health.

3. Clinical Trials

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

- Cancer or other Life-Threatening disease or condition.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when you are:

- Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition, or
- Either:
 - the referring health care professional is a participating health care provider and has concluded that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial, or
 - you provide medical and scientific information establishing that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial.

Routine patient care costs for qualifying clinical trials include:

- With respect to a clinical trial for the treatment of cancer, the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be Covered Health Care Services under the Policy if those drugs, items, devices and services were not provided in connection with an approved clinical trial program.
- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s), drug, item or device.
 - The clinically appropriate monitoring of the effects of the Experimental or Investigational Service(s), drug, item or device.
 - The prevention of complications arising from the provision of the Experimental or Investigational Service(s), drug, item or device.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Investigational, drug, item, device or service, including the diagnosis of treatment of the complications.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other Life-Threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other Life-Threatening disease or condition, including involving a drug that is exempt under federal regulations from a new drug application. It meets any of the following criteria in the bulleted list below.

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

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

With respect to a clinical trial for the treatment of cancer or other Life-Threatening disease or condition, Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers.

4. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

5. Dental Services - Accident Only

Dental services when all of the following are true:

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

Please note that dental damage that happens as a result of normal activities of daily living, such as chewing and/or biting, 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 the accidental health condition must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, 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, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of the accidental health condition are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.

- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to health condition with implant, dentures or bridges.

6. Diabetes Services

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

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

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

7. Diabetes Treatment

Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Benefits for diabetes prescription items (limited to insulin, medication for the treatment of diabetes, and glucagon) are described in the *Outpatient Prescription Drug Rider*.

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

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

DME and Supplies

Examples of DME and supplies include:

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

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

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

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

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

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

9. Emergency Health Care Services - Outpatient

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

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

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

10. Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Care and Substance-Related and Addictive Disorders Services*.
- Cross-sex hormone therapy:
 - Cross-sex hormone therapy administered by a medical provider (for example during an office visit).
 - Cross-sex hormone therapy dispensed from a pharmacy as provided under your *Outpatient Prescription Drug Rider*.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Any other reconstructive surgery necessary to create a normal appearance for the gender with which you identify.

11. Habilitative Services

Benefits for habilitative services will be covered under the same terms and conditions applied to rehabilitative services under the Policy. Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- The initial or continued treatment must not be an Unproven Service or Experimental or Investigational. This condition does not apply to Medically Necessary occupational therapy or speech therapy if you have a diagnosis of pervasive developmental disorder or Autism Spectrum Disorder.
- Treatment is administered by any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.

For purposes of this Benefit, "habilitative services" means skilled health care services that are part of a prescribed plan of treatment to that help a person with a disabling condition to learn, maintain or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Therapies provided for the purposes of general well-being or conditioning in the absence of disabling condition are not considered Habilitative Services.

Habilitative services are limited to:

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

The following are not Habilitative Services:

- Custodial care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan, including diagnosis, proposed treatment by type, frequency and expected duration of treatment, expected treatment goals and frequency of treatment plan updates.
- Medical records.
- Clinical notes.

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

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

12. Hearing Aids

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

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

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

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

13. Home Health Care

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

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

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management.

14. Hospice Care

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

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

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

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

15. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

16. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Benefits are provided whether mammography testing is ordered or referred by a Physician, a nurse practitioner or a certified nurse midwife.
- All generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services*.)

Benefits include:

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

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

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

17. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Covered Health Care Services under this section include all generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services*.)

Benefits include:

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

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

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a Physician acting within the scope of his or her license.

Benefits for Mental Health Care include Covered Health Care Services for the diagnosis and treatment of Mental Illnesses. Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Emergency Health Care Services.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Prescription drugs.
- Medication-assisted treatment for Substance-Related and Addictive Disorders Services.
- Office-based medication-assisted opioid treatment, including methadone.
- Medication-assisted opioid treatment programs, including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program.
- Treatment programs at federally certified Methadone clinics.

Benefits for Covered Health Care Services provided on an outpatient basis are separated into the following two (2) categories in the Schedule of Benefits for the purpose of establishing the cost share that applies to the Benefit:

- *Outpatient Office Visits:*
 - Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, medication management, office-based medication-assisted opioid treatment, including methadone, and treatment programs at federally certified methadone clinics.
- *All Other Outpatient Treatment:*
 - Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders delivered at home, medication-assisted opioid treatment programs including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.

Benefits under this section also include the diagnosis and all Medically Necessary treatment of Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child. These Benefits are subject to the Mental Health Care Services and Substance-Related

and Addictive Disorders Services cost sharing, including the classification or sub-classification that applies.

Covered Health Care Services provided for Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child must meet the definitions of Severe Mental Illness or Serious Emotional Disturbances as defined in this *Certificate* in *Section 9: Defined Terms*.

Benefits include Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:

- Based on an asserted need for cognitive or intelligence quotient (IQ) testing;
- On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

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

For non-emergency, out-of-Network, inpatient behavioral health care, prior authorization may be required. If so, you must contact the Mental Health/Substance-Related Addictive Disorders Designee for referrals to providers and coordination of care and failure to obtain prior authorization from the designee will result in a penalty. Please refer to the *Mental Health Care and Substance-Related and Addictive Disorders Services* Benefit category in the Schedule of Benefits for information on the prior authorization requirements and penalty, if applicable.

For all other levels of care, we encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care, but you are not required to do so and you will not be subject to a penalty if you do not.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described under *Section 6: Questions, Complaints and Appeals*. You can call us at the telephone number on your ID card.

19. Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when you have a body mass index (BMI) equal to or greater than 40 or equal to or greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

20. 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.

21. Pharmaceutical Products - Outpatient

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

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

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

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

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

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

22. Physician Fees for Surgical and Medical Services

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

23. Physician's Office Services

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

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

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

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

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

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

24. Pregnancy - Maternity Services

Benefits for Pregnancy include prenatal care, pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

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

We also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

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.

When the mother and child are discharged early, coverage is provided for at least one post discharge follow-up visit within 48 hours of discharge, when prescribed by the treating Physician. A post discharge visit must be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit includes, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating Physician, in consultation with the mother, will determine whether the post discharge visit occurs at home, a birth facility, or the treating Physician's office. Prenatal diagnosis and counseling for genetic disorders are covered.

We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.

25. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law (<https://www.healthcare.gov/coverage/preventive-care-benefits/>):

- 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* (<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>), including:
 - Intensive behavioral counseling interventions for healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease risk factors. Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors. For adults who are overweight or obese (overweight (BMI > 25) or obese (BMI \geq 30)) and have additional CVD risk factors (hypertension, dyslipidemia,

- impaired fasting glucose, or metabolic syndrome), 12-26 sessions per year of intensive behavioral counseling interventions to promote a healthful diet and physical activity.
- Screening for abnormal blood glucose in adults aged 40 to 70 years who are overweight (BMI > 25) or obese (BMI \geq 30). For individuals with abnormal blood glucose, 12-26 sessions per year of intensive behavioral counseling interventions to promote a healthful diet and physical activity.
 - Cancer screening tests and counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions.
 - Screening tests for hereditary breast and ovarian cancer are covered as a preventive care service when they are an "A" or "B" recommendation of the *United States Preventive Services Task Force*.
 - Tobacco use and tobacco-related disease counseling and interventions. For each quit attempt, the following benefits are provided without prior authorization when prescribed:
 - ◆ A minimum of four in-person tobacco cessation counseling sessions (including group counseling and individual counseling), as well as 3 telephone counseling sessions, all of which are at least 10 minutes; AND
 - ◆ Self-help materials that are tailored to the individual patient; AND
 - ◆ All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications, and including combining multiple medications) for a minimum of the length of time specified in the product labeling.
 - ◆ There is no limit on the number of tobacco cessation attempts covered during the plan year.
 - Aspirin preventive medication: adults aged 50 to 59 years with a \geq 10% 10-year cardiovascular risk.
 - Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
 - Folic acid supplementation for women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μ g) of folic acid.
 - Statin preventive medication for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors, and a calculated 10-year cardiovascular disease event risk of 10% or greater.
 - Bowel preparation medications, when medically appropriate and prescribed by a health care provider, are an integral part of the preventive screening colonoscopy, and required to be covered in accordance with the requirements of PHS Act section 2713 and its implementing regulations.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including FDA approved AIDS vaccine if recommended by the *United States Public Health Services* (<https://www.cdc.gov/vaccines/schedules/resource-library/index.html>)
 - 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 (<https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html>), including screening for blood lead levels, Phenylketonuria (PKU)

testing, periodic health evaluations, and laboratory services in connection with periodic health evaluations. The *Uniform Screening Panel* recommended by the *U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children*.

Benefits are also provided for wellness examinations (well-baby, well-child) in accordance with the *American Academy of Pediatrics* and *American Academy of Family Physicians* age and frequency guidelines and include:

- Screening newborns for hearing problems, thyroid disease, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
- For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders.
- Screening and counseling for obesity in children and adolescents. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including comprehensive, intensive behavioral interventions to promote improvement in weight status. Screening for obesity in children and adolescents beginning at 24 months. For obese children and adolescents ages 6-21, at least 26 -52 contact hours per year of comprehensive, intensive behavioral interventions to promote improvement in weight. Comprehensive means: sessions targeting both the parent and child (separately, together, or both); individual sessions (both family and group); providing information about healthy eating, safe exercising, and reading food labels; encouraging the use of stimulus control (e.g., limiting access to tempting foods and limiting screen time), goal setting, self-monitoring, contingent rewards, and problem solving; and supervised physical activity sessions.

Benefits for preventive care for children will be consistent with both of the following:

- The *Recommendations for Preventive Pediatric Health Care*, as adopted by the *American Academy of Pediatrics* as identified in the *Bright Futures Recommendations for Preventive Pediatric Health Care* (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Which includes BMI screening beginning at 24 months.
- The most current version of the *Recommended Childhood Immunization Schedule/United States*, jointly adopted by the *American Academy of Pediatrics*, the *Advisory Committee on Immunization Practices*, and the *American Academy of Family Physicians*, unless determined otherwise by the *State Department of Health Services*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration Women's Preventive Services Guidelines* (<https://www.hrsa.gov/womens-guidelines-2016/index.html>), including breast cancer screening, annual cervical cancer screening, osteoporosis screening and screening mammography. Benefits for preventive care visits include preconception and prenatal services.
- Covered Health Care Services also include voluntary family planning and all *FDA*-approved contraceptive drugs, devices, and other products for women as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law, including but not limited to the following services:
 - Office visits, examinations, patient education and counseling on contraception (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
 - Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).

- Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
- Follow-up services related to all *FDA*-approved contraceptive drugs, devices, and other products (including all *FDA*-approved over-the-counter drugs, devices, and other products) for women. Follow-up services include, but are not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
- Voluntary female sterilization procedures, including surgical sterilization (tubal ligation) and implantable sterilization.

Benefits also include *FDA*-approved contraceptive drugs, devices, and products available over-the-counter when prescribed by a Network provider.

Note: This plan covers up to a 12-month supply of *FDA*-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

- Prescription Drug Products prescribed to prevent conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- *FDA*-approved contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.

A complete list of Preventive Care Medications covered under the Preventive Care Services benefit can be found at myuhc.com, under Pharmacy Information. The Preventive Care List is labeled "HCR Preventive Care" on the PDL (Prescription Drug List) used by your plan. Preventive Care Medications can be obtained at Network Pharmacies with a prescription from a Physician.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one hospital grade breast pump and double breast pump kit per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits for a hospital grade breast pump and double breast pump kit are provided taking into account the following determinations:

- Which pump is the most cost effective.
 - Whether the pump should be purchased or rented.
 - Duration of a rental.
 - Timing of purchase or rental.
- With respect to men, additional screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.
 - Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
 - Routine non-pediatric eye exam services for preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
 - Hearing exams to find out the need for hearing correction, for all ages.
 - Screening for obesity in all adults. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including intensive,

multicomponent behavioral interventions for Covered Persons with a body mass index (BMI) of 30 kg/m² or higher. For obese adults, 12-26 sessions per year of intensive, multicomponent behavioral interventions for weight management. Multicomponent means: Group and individual sessions of high intensity (12 to 26 sessions in a year); Behavioral management activities, such as weight-loss goals; Improving diet or nutrition and increasing physical activity; Addressing barriers to change; Self-monitoring; and Strategizing how to maintain lifestyle changes.

California mandated preventive health care services:

As required under California law, Benefits under this section include:

- Screening for blood lead levels in children who are at risk for lead poisoning as determined by a health care provider in accordance with standards adopted by the California Department of Public Health.

26. Prosthetic Devices

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

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

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

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

The prosthetic device must be prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license or is ordered by a licensed health care provider acting within the scope of his or her license.

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

27. Reconstructive Procedures

Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- To improve function.
- To create a normal appearance, to the extent possible.

Reconstructive procedures include surgery or other procedures which are related to a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Cosmetic Procedures are excluded from coverage.

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

28. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Benefits are provided for rehabilitative services when you have a disabling condition and both of the following conditions are met:

- The initial or continued treatment must not be an Unproven Service or Experimental or Investigational Service. This condition does not apply to Medically Necessary occupational therapy or speech therapy if you have a diagnosis of pervasive developmental disorder or Autism Spectrum Disorder.
- Treatment is administered by any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.

For purposes of this Benefit, "rehabilitative services" means Skilled health care services that are part of a prescribed plan of treatment to help a person to regain, maintain, or prevent deterioration of, skills and functioning for daily living that were previously acquired but then lost or impaired due to illness, injury or disabling condition. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Therapies provided for the purposes of general well-being or conditioning in the absence of disabling condition are not considered Rehabilitative Services.

Short-term outpatient rehabilitation services limited to:

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

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

The following are not rehabilitative services:

- Custodial care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan, including diagnosis, proposed treatment by type, frequency and expected duration of treatment, expected treatment goals and frequency of treatment plan updates.
- Medical records.
- Clinical notes.

29. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

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

Benefits include:

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

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

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

30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management.

31. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

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

Benefits include:

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

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

32. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles.

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

Non-surgical treatment including:

- Clinical exams.
- Physical therapy.
- Pharmacological therapy.

- Oral appliances (orthotic splints).
- Joint injections.
- Trigger-point injections.

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

- There is radiographic evidence of joint abnormality and the procedure being considered for reimbursement is Medically Necessary.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include *FDA*-approved TMJ prosthetic replacements when all other treatment has failed.

33. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including:

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

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

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

Benefits include:

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

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

34. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

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

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

Benefits for transplantation services are available to Covered Persons with human immunodeficiency virus (HIV) under the same terms and conditions available to Covered Persons without HIV.

35. Urgent Care Center Services

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

36. Virtual Visits

Virtual visits is distinct from Telehealth services since there are no restrictions on where virtual visit services can originate. Virtual visits covers audio visual visits with a Physician from a designated network and is accessible from any location not limited to home or office or CMS originating site. Unlike Telehealth Services, it requires audio visual medium to facilitate face-to-face interaction for an appropriate evaluation and diagnosis.

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).

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

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

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

37. Vision Exams

Routine vision exams received from a health care provider in the provider's office. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams required for the diagnosis and treatment of a health condition are provided under *Physician's Office Services*.

38. Wigs

Wigs and other scalp hair prosthesis regardless of the reason for hair loss.

Additional Benefits Required By California Law

39. Breast Cancer Services

Benefits include diagnosis of, and treatment for, breast cancer. (Benefits for breast cancer screening are described under *Preventive Care Services*.)

40. Dental Anesthesia Services

Services including general anesthesia and associated Hospital or Alternate Facility charges when your clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Alternate Facility setting. Services are limited one of the following:

- A child under seven years of age.
- A person who is developmentally disabled, regardless of age.
- A person whose health is compromised and for whom general anesthesia is required, regardless of age.

Services for the diagnosis or treatment of a dental disease are not Covered Health Care Services.

41. Mastectomy Services

Coverage for mastectomies and lymph node dissections is provided in the same manner as other covered surgeries. The length of Hospital stay is determined by the attending Physician in consultation with the patient. We will not require the attending Physician to obtain prior approval of the length of the Hospital stay. The Policy covers all complications from a mastectomy including lymphedema. The Policy covers prosthetic devices and reconstructive surgery to restore and achieve symmetry for the patient, subject to the Policy's deductible and Co-payment requirements.

42. Off-Label Drug Use and Experimental or Investigational Services

Off-label drug use means that a Physician or provider has prescribed a drug approved by the *Food and Drug Administration (FDA)* for a use that is different than for which the *FDA* approved the drug. If a drug is prescribed for off-label drug use, the drug and administration will be a Covered Health Care Service only if it satisfies the following criteria:

- The drug is approved by the *FDA*.
- The drug is prescribed by a Network Physician or provider for the treatment of a Life-Threatening condition or
- The drug is prescribed by a Network Physician or provider for the treatment of a Chronic and Seriously Debilitating condition, the drug is medically necessary to treat that condition.
- The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by two articles from major peer reviewed medical journals that present data supporting proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Benefits for Experimental or Investigational Services are limited to the following:

- Clinical trials for which Benefits are available as described under *Clinical Trials* above.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* above, and you have a Life-Threatening or seriously debilitating condition (disease or conditions that cause major irreversible morbidity), we may consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that health 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 health condition.

Nothing in this section shall prohibit us from use of a formulary, Co-payments or Co-insurance, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the *FDA*. However, coverage will be provided for off-label use when a drug that is not listed on the formulary is prescribed for a Life-Threatening condition as outlined in this section. Benefits will also include Medically Necessary Covered Health Care Services associated with the administration of a drug subject to the conditions of this Policy.

If Benefits are denied as an Experimental, Investigational or Unproven Service, you may appeal the decision through independent external medical review as described under *Denial of Experimental, Investigational or Unproven Services* in *Section 6: Questions, Complaints and Appeals*. You can call us at the telephone number on your ID card.

43. Osteoporosis Services

Services related to diagnosis, treatment, and appropriate management of osteoporosis. Services include, but are not limited to, all *FDA*-approved technologies and bone mass measurement. (Benefits for osteoporosis screening are described under *Preventive Care Services*.)

44. Phenylketonuria (PKU) Treatment

Benefits for the testing and treatment of phenylketonuria (PKU). (Benefits for PKU testing are described under *Preventive Care Services*.) Coverage includes Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specialized in the treatment of metabolic disease. The diet must be needed to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

"Formula" means an enteral product or enteral products for use at home that are prescribed by a Physician for the treatment of phenylketonuria (PKU).

"Special Food Product" means a food product that is both of the following:

- Prescribed by a Physician for the treatment of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
- Used in place of normal food products, such as grocery store foods, used by the general public.

45. Prosthetic Devices - Laryngectomy

Benefits for prosthetic devices to restore a method of speaking incident to laryngectomy. This includes the initial and subsequent prosthetic devices, including installation accessories, as ordered by a Physician. Electronic voice producing machines are not covered.

46. Telehealth Services

Benefits are available for Covered Health Care Services received through Telehealth. No in-person contact is required between a licensed health care provider and you for Covered Health Care Services appropriately provided through Telehealth, subject to all terms and conditions of the Policy.

Prior to the delivery of Covered Health Care Services via Telehealth, the health care provider at the originating site shall verbally inform you that Telehealth may be used and obtain verbal consent from you for this use. The verbal consent shall be documented in your medical record.

We shall not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Benefits will not be excluded, limited or reduced solely due to conditions attributable to or exposure to diethylstilbestrol.

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

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

This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in *Section 1: Covered Health Care 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 Care Services*.

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Removal, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
5. Treatment of congenitally missing, malpositioned or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to

braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to help in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Care Services* and speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

Note: The following exclusions apply only to prescription drug products and Pharmaceutical Products covered under the medical Benefits described in this *Certificate*. These exclusions do not apply to prescription drug products covered under the *Outpatient Prescription Drug Rider*.

1. Prescription drug products for use outside of a healthcare setting that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use). This exclusion does not apply to prescription drug products covered under the *Outpatient Prescription Drug Rider*.
2. Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications that are covered under the *Outpatient Prescription Drug Rider*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments that are covered under the *Outpatient Prescription Drug Rider*. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.

5. Growth hormone therapy for non-*FDA* approved uses only. This exclusion does not apply to growth hormone therapy that is covered under the *Outpatient Prescription Drug Rider*.
6. Certain Pharmaceutical Products are not covered unless they are prescribed by a Specialist.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded except Benefits provided for clinical trials for cancer or other Life-Threatening disease or condition and for Experimental or Investigational Services and Unproven Services as defined under *Section 9: Defined Terms* and except that coverage which is provided for an *FDA*-approved drug prescribed for a use that is different from the use for which the *FDA* approved it, when needed for treatment of a Chronic and Seriously Debilitating or Life-Threatening condition. The drug must appear on the formulary list, when it is prescribed off-label for the treatment of a Chronic and Seriously Debilitating condition. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium* or *Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in *Section 1: Covered Health Care Services*. This exclusion does not apply to Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorder.

F. Foot Care

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

This exclusion does not apply to preventive foot care if you 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. This exclusion does not apply to shoes for which Benefits are provided as described under *Diabetes Treatment* in *Section 1: Covered Health Care Services*.
7. Shoe orthotics.
8. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under *Diabetes Treatment* in *Section 1: Covered Health Care Services*.

9. Arch supports.

G. Medical Supplies and Equipment

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:

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

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

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

1. Services performed in connection with conditions not classified as mental disorders in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
3. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*. This exclusion will not affect or reduce any obligation to provide services for Severe Mental Illness, Serious Emotional Disturbances, pervasive developmental disorder or Autism Spectrum Disorders as required by California law.
4. Transitional Living services.

I. Nutrition

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

J. 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 and as required by California regulation.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.

- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*.

This exclusion does not apply to *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

Examples of Cosmetic Procedures include:

- Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
2. Treatment of benign gynecomastia (abnormal breast enlargement in males). This exclusion does not apply to the reconstructive and Medically Necessary treatment of benign gynecomastia for male patients. This exclusion does not apply to reconstructive surgery when gynecomastia is caused by disease.
 3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.

4. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to intensive behavioral interventions for which Benefits are provided as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
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. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
5. Biofeedback.
6. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
7. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in *Temporomandibular Joint (TMJ) Services* under *Section 1: Covered Health Care Services*. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.
8. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under *Other Health Education Services for You* in the section of the *Certificate* titled *Our Responsibilities*. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
9. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*. This exclusion does not apply to any other reconstructive surgery necessary to create a normal appearance for the gender with which you identify as described under *Gender Dysphoria* in *Section 1: Covered Health Care Services*.
10. Helicobacter pylori (*H. pylori*) serologic testing.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility

or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

- Has not been involved in your medical care prior to ordering the service, or
- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Gestational carrier (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. In vitro fertilization regardless of the reason for treatment.

O. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services during active military duty, when you are on active duty for more than 30 days.

P. Transplants

4. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
5. Health care services for transplants involving permanent mechanical or animal organs.
6. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants. This exclusion does not apply when a Designated Provider is not available with the time and distance or appointment waiting time standards required by California regulation.

Q. Travel

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

R. Types of Care

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

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix 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:
 - You have craniofacial anomalies in which normal or absent ear canals prevent the use of a wearable hearing aid; or
 - You have hearing loss of sufficient severity that it cannot be remedied enough by a wearable hearing aid.

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

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following:
 - Medically Necessary.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.

- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in the United States or non-war zones outside the United States.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. Charges in excess of the Allowed Amount or in excess of any specified limitation. This exclusion does not apply when we arrange access to medically appropriate care from a qualified out-of-Network provider if medically appropriate care cannot be provided within the Network. You will only be responsible for paying cost-sharing in an amount equal to the cost-sharing you would have paid for provision of that or a similar service in-Network.
 7. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products.
 8. Autopsy.
 9. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services that are Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

What If You Are Eligible for Medicare?

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Dependent

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

All newborn Dependent children of the Subscriber are covered from the moment of birth. All newly adopted Dependent children of the Subscriber are covered from and after the moment the child is placed in the physical custody of the Subscriber for adoption. However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 31 days of the event.

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended due to situations allowing for a rescission (fraud or intentional misrepresentation of a material fact), or because premiums were not paid on a timely basis.

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program in California). 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, including the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period or the Eligible Person or Dependent is employed by an employer that offers multiple health benefit plans and the person elected a different plan during Open Enrollment; and coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including termination of employment, reduction in the number of hours of employment, legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.
 - Loss of minimum essential coverage, including, but not limited to, loss of eligibility for coverage as a result of the following: legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, termination of employer contributions, and exhaustion of COBRA continuation

coverage; loss of coverage because the covered employee becomes eligible for Medicare; and bankruptcy of the employer from whose employment the covered employee retired; loss of coverage due to an act or practice that constituted fraud, or an intentional misrepresentation of a material fact.

- Gaining or becoming a dependent (due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship).
- State or Federal Court mandate to be covered as a Dependent.
- Release from incarceration.
- Health coverage issuer substantially violated a material provision of the health coverage contract.
- Gaining access to new health benefit plans as a result of a permanent move.
- Receiving services from a contracting provider under another health insurance plan for (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, health condition, or other medical problem that requires prompt medical attention and that has a limited duration), (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration), (c) a pregnancy, (d) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), (e) care of a newborn child between birth and age 36 months, or (f) performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health benefit plan.
- Being misinformed that one had minimum essential coverage.
- Returning from active duty of the reserve forces of the United States military or the California National Guard.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 60 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

If UnitedHealthcare Insurance Company can demonstrate that you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may rescind or cancel your coverage, with written notice of your right to appeal.

After 24 months following the issuance of the Policy, we will not rescind the Policy for any reason, and will not cancel the Policy, limit any of the provisions of the Policy, or raise the Policy Charge due to any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

If we rescind or cancel your coverage, we will send the Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission or cancellation explaining the reasons for the intended rescission or cancellation and information on how to file an appeal of the decision with the California Department of Insurance. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may cancel your coverage, as permitted by law. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions allowed by law, which may include demanding 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.

Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TTY 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles, CA 90013**

Or through the website <http://www.insurance.ca.gov>.

Coverage for a Disabled Dependent Child

Continued Enrollment of a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached 26 years old. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because a physically or mentally disabling illness or health condition.
- The Enrolled Dependent child depends chiefly on the Subscriber for support.

At least 90 days prior to the date the Enrolled Dependent child attains the limiting age, we will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age, unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will notify the subscriber of confirmation of the extended coverage.

If we fail to notify the Subscriber prior to the date of the Enrolled Dependent attaining age 26, coverage of the Enrolled Dependent child will continue pending confirmation the Enrolled Dependent meets the criteria.

We may continue to ask you for proof that the child continues to be disabled and dependent. We will not ask for this information more than once a year after a two-year period following the child's attainment of the limiting age.

If the Subscriber or Covered Person changes carriers to another insurer or to a health care service plan ("plan"), the new insurer or plan will continue to provide coverage for the Dependent child. The new insurer or plan may request information about the Dependent child initially and not more frequently than annually thereafter to confirm the Dependent child continues to satisfy the following criteria:

- Is not able to be self-supporting because of a physically or mentally disabling illness or health condition.
- Depends chiefly on the Subscriber for support.

The Subscriber or Covered Person must submit the information requested by the new insurer or plan within 60 days of receiving the request.

Initial Enrollment of a Disabled Child

A disabled Dependent child who is age 26 or older will be continued to be enrolled under the Policy if he or she is enrolled at the time he or she attains age 26, provided that satisfactory evidence of such disability is provided to us during the period commencing 60 days before and ending 60 days after the Dependent child's 26th birthday.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation of Coverage

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

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

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

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

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

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

- Notifying us in a timely manner of your election of continuation coverage.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

A qualified beneficiary is an individual who was covered under the Policy and has also exhausted their continuation coverage under Federal law (COBRA) for which they were entitled to less than 36 months of coverage. Extended continuation coverage under state law (Cal-COBRA) may be obtained for up to 36 months from the date that the COBRA continuation began.

Qualifying Events for Continuation Coverage under State Law (Cal-COBRA)

The date of your "Qualifying Event" is the date that continuation coverage began under your federal COBRA continuation.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal-COBRA)

Notification of any right to extended coverage under Cal-COBRA will be provided to you by us within 90 days prior to your termination under COBRA. Continuation must be elected within 30 days of when COBRA continuation is scheduled to end.

The Group or the Group's designated plan administrator will notify you of any annual Benefit or Premium changes that may occur during your Open Enrollment Period.

Termination Events for Continuation Coverage under State Law (Cal-COBRA)

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

- Thirty-six months from the date of your qualifying event.
- The date, after electing continuation coverage, that the qualified beneficiary first becomes entitled to Medicare.
- The date, after electing continuation coverage that the qualified beneficiary has other hospital, medical or surgical coverage, or is or becomes covered under another group health plan.
- The date the qualified beneficiary is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act.
- The date coverage terminated under the Policy for failure to make timely payment of the Premium.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading Events Ending Your Coverage.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us.

Notice of Claim: Written notice of claim must be furnished to us within 20 days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

Proof of Loss: Written proof of loss must be provided to us within 90 days after the date the service was received. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms: Upon receipt of a written notice of a claim, we will provide you with claim forms for filing proof of loss. If we do not provide claim forms to you within 15 days after we receive written notice of a claim from you, you will have deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the timeframe for filing a proof of loss (as described above), written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

As a third alternative, you may provide us with all of the following specific information in lieu of the claim form:

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

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

Time of Payment of Claim: Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid (to the Subscriber) as they accrue and any balance remaining unpaid at termination of the period of liability will be paid (to the Subscriber) immediately upon receipt of due written proof.

Payment of Claims to the Subscriber: Subject to any written direction of the Subscriber in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at our option, and unless the Subscriber requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

We will reimburse claims or any portion of any claim, whether in-state or out-of-state, for Covered Health Care Services, as soon as possible, no later than 30 working days after receipt of the claim.

However, a claim or portion of a claim may be contested or denied by us. In that case, you will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Covered Person who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 30 working days after receipt, we will pay interest at the rate of 10% per annum beginning with the first calendar day after the 30-working-day period.

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

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

Section 6: Questions, Complaints and Appeals

IMPORTANT NOTICE - CLAIM DISPUTES

Should a dispute concerning a claim arise, contact us first. If the dispute is not resolved contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the California Department of Insurance at:

- **1-800-927 HELP (1-800-927-4357)**
- **1-800-482-4833 (TTY)**

You may write the California Department of Insurance at:

**California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013**

Or through the website <http://www.insurance.ca.gov>.

For further information about complaint procedures please read the section below.

IMPORTANT NOTICE - NETWORK PROVIDER ACCESSIBILITY COMPLAINTS

If you have a complaint regarding your ability to access Covered Health Care Services from a Network provider in a timely manner, call the telephone number shown on your ID card. If you would rather send your complaint to us in writing, a representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

- **1-800-927-HELP (1-800-927-4357)**
- **1-800-482-4833 (TTY)**

You may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013**

Or through the website <http://www.insurance.ca.gov>.

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

What to Do if You Disagree with Our Adverse Benefit Determination

If you disagree with our Adverse Benefit Determination, you may file a formal appeal. Our internal review appeals procedures are designed to deliver a timely response and resolution to your appeal. We will continue to provide coverage for the Covered Health Care Service under review until the Adverse Benefit Determination is resolved.

An Adverse Benefit Determination is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Service or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.

- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

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

Appeals Determinations

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

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

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

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. (For procedures associated with non-Urgent Requests for Benefits based on Medical Necessity for Benefits, see *Non-Urgent Pre-Service Requests Based on Medical Necessity* below.)
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days of the receipt of information that is reasonably necessary to make this determination. The determination will be communicated to the provider in a manner that is consistent with current law.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

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

Non-Urgent Pre-Service Requests Based on Medical Necessity

Decisions to deny or modify requests for authorization of Covered Health Care Services, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals. The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of Covered Health Care Services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of your

condition, not to exceed five business days from our receipt of the information reasonably necessary and requested to make the decision.

- If your condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to your life or health, the decision will be rendered in a timely fashion appropriate for the nature of your condition, but not later than 72 hours after our receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because: (1) we are not in receipt of all of the information reasonably necessary and requested or (2) consultation by an expert reviewer is required, or (3) the reviewer has asked that an additional examination or test be performed upon you, provided the examination or test is reasonable and consistent with good medical practice, the reviewer will notify the Physician and you, in writing, upon the earlier of the expiration of the required time frame above or as soon as we become aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by us, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

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, 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 decided within 5 business days of the request.

We will provide continued coverage pending the outcome of an appeal. We will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Life-Threatening or seriously debilitating condition, we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.
- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and participate in the review. An external review will be provided to you within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of you getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Health Care Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services.

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.
2. Agree and provide written consent to participate in IMR.
3. The CDI determines if the request is eligible for IMR.
4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to you, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.
6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify you and us. The decision is binding on UnitedHealthcare Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Health Care Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Insurance:

You may contact the California Department of Insurance for information on the independent external review program by calling:

- **1-800-927 HELP (1-800-927-4357)**
- **1-800-482-4833 (TTY)**

You may also write the California Department of Insurance at:

**California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013**

Or through the website <http://www.insurance.ca.gov>.

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 based on California regulations.

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

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

other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

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

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

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

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

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a 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 period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

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

addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

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

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We offer health care coverage to Eligible Persons with a physical handicap under the same terms and conditions as are offered to Eligible Persons without a physical handicap. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. Your right to Benefits is limited to the Covered Health Care Services described in *Section 1: Covered Health Care Services*. If you choose to receive a service that is not a Medically Necessary Covered Health Care Service under the Policy, you will be responsible for paying all charges and no Benefits will be paid.

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

Notice

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

We will provide notice to the Group and all affected Subscribers if either of the following occurs:

- **For discontinuance of a particular health benefit plan.** Your coverage may be terminated if UnitedHealthcare decides to cease offering the a particular health benefit plan upon 90 days written notice to the California Department of Insurance, the Group and all affected Subscribers covered under the health benefit plan. When a health benefit plan is discontinued, UnitedHealthcare will make all other health benefit plans offered to new group business available to the Group without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.
- **For discontinuance of all new and existing health benefit plans.** Your coverage may be terminated if UnitedHealthcare decides to cease offering existing or new plans in the group market in the State of California upon 180 days written notice to the California Department of Insurance, the Group and all affected Subscribers covered under the health benefit plans.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy, including fraud or an intentional misrepresentation of a material fact, after twenty-four (24) months from the date of issuance of the Policy.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

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

Who Interprets Benefits and Other Provisions under the Policy?

We will do the following:

- Pay Benefits according to the Policy.
- Pay Benefits according to this Policy and subject to 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.
- Other persons or entities may provide services in regard to the administration of the Policy.

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

Who Provides Administrative Services?

We provide administrative services or we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice

of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Physical Examinations and Autopsy: We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Medicare Eligible?

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

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

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

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

Reimbursement - Right to Recovery

In consideration of the coverage provided by this *Certificate of Coverage*, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity who is liable for payment to you on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
 - providing any relevant information requested by us,
 - signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim,
 - responding to requests for information about any accident or injuries, and
 - making court appearances, we will not require you to travel more than 60 miles from home for a court appearance without reimbursing your reasonable expenses.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced. Benefits are considered benefits advanced where it is either now known or later known that some other party may be the primary payor. Benefits advanced will be expected to be repaid through either coordination and/or reimbursement.
- You agree to advise us, in writing, within a reasonable time of your claim against the third party and to take such action, provide such information and assistance, and execute such documents as we may reasonably require to facilitate enforcement of the claim. We may have a right to a lien, to the extent of benefits advanced, upon any recovery that you receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise.
- That the provisions of this section will apply to your survival claim, estate, and/or the personal representative of your estate.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

When Do We Receive Refunds of Overpayments?

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

- Our files contain clear, documented evidence of an overpayment and written authorization from you or assignee, permitting the reimbursement or withholding procedure or
- Our files contain clear, documented evidence of the following:
 - The overpayment was erroneous under the provisions of the Policy.
 - The error which resulted in the payment is not a mistake of the law.

- We notify you within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, we notify you within fifteen (15) calendar days after the date of discovery of such error. The date of the error will be the day on which the draft for Benefits is issued.
- The notice clearly states the cause of the error and states the amount of the overpayment.
- The procedure described above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

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

If you do not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Policy.

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

Change of Beneficiary

The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to change of beneficiary or beneficiaries, or to any other changes in this Policy. Please refer to *Section 3: When Coverage Begins* for information on who is eligible for coverage under the Policy.

Non-Discrimination in Contract Availability or Terms

No admitted insurer, licensed to issue disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefore, or issue or cancel that insurance, under conditions less favorable to the Eligible Person than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, sex, gender, gender identity, gender expression, national origin, ancestry or sexual orientation.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof is required to be furnished.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the *Group's Application* and any Riders and/or Amendments, make up the entire Policy between the parties, and any statement made by the Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Eligible Person whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

Section 9: Defined Terms

Adverse Benefit Determination - Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is an Experimental or Investigational Service or not Medically Necessary or appropriate. An adverse benefit determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are explained in the *Schedule of Benefits*.

Allowed Amounts are calculated in accordance with our reimbursement policy guidelines. We develop these guidelines after review of all provider billings in accordance with one or more of the following methodologies:

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

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

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

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

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

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

Autism Spectrum Disorder - including pervasive developmental disorder, is a condition defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Health Treatment - professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the

maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or Autism Spectrum Disorders, and that meet all of the following criteria:

- The treatment is prescribed by a Physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the California Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
 - A qualified autism service provider.
 - A qualified autism service professional supervised and employed by the qualified autism service provider.
 - A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific Covered Person being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
 - Describes the Covered Person's behavioral health impairments to be treated.
 - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Covered Person's progress is evaluated and reported.
 - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or Autism Spectrum Disorders.
 - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

In applying the above definition, "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" shall have the following meanings:

- "Qualified autism service provider" means either of the following:
 - A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
 - A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the licensee.

- "Qualified autism service professional" means an individual who meets all of the following criteria:
 - Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
 - Is supervised by a qualified autism service provider.
 - Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
 - Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.
 - Has training and experience in providing services for pervasive developmental disorder or Autism Spectrum Disorders pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
 - Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

- "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
 - Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
 - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
 - Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
 - Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
 - Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

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

Chronic and Seriously Debilitating - diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

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

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

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

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that are performed to alter or reshape normal structures of the body in order to improve your appearance.

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

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

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

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

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Dependent - the Subscriber's legal Spouse, Domestic Partner or a child of the Subscriber or the Subscriber's Spouse or Domestic Partner. All references to the Spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- An adopted child.
- A child placed for adoption.
- Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes a child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

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

Enrollment may not be denied based on any of the following facts:

- The child does not reside with the Subscriber.

- The child is born out of wedlock.
- The child is not claimed as a dependent on the Subscriber's federal or state income tax.
- The child lives outside the service area.

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

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's child, the child will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this Policy.
- The Group has eliminated dependent health coverage for all its Subscribers.
- The Subscriber is no longer eligible for coverage.

We will notify both parents and any other person having custody of a child in writing at any time that health insurance for the child is terminated.

When a child is enrolled in a plan of the non-custodial parent or a parent sharing custody or temporary control of the child, we will:

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.
- Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

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

Designated Provider - a provider and/or facility that:

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

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

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

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

Domestic Partner - a person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
 - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
 - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

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

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

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

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- Placing the health of the Covered Person's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Active labor, meaning labor at a time that either of the following would occur;
 - There is inadequate time to effect safe transfer to another Hospital prior to delivery, or
 - A transfer poses a threat to the health and safety of the Covered Person or unborn child.

An Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Covered Person as being either of the following:

- An immediate danger to himself or herself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials in Section 1: Covered Health Care Services*.
- External, independent review process as described under *Denial of Experimental, Investigational or Unproven Services in Section 6: Questions, Complaints and Appeals*.
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials in Section 1: Covered Health Care Services*: and you have a Life-Threatening or seriously debilitating condition (disease or conditions that cause major irreversible morbidity). A seriously debilitating condition is a disease or condition that causes major irreversible morbidity.
- Off-Label Drug Use and Experimental or Investigational Services for which Benefits are available as described under *Off-Label Drug Use and Experimental or Investigational Services in Section 1: Covered Health Care Services*.
 - The drug is prescribed by a Network Physician or provider for the treatment of a Chronic and Seriously Debilitating condition, the drug is medically necessary to treat that condition and the drug must appear on the formulary list, if applicable.
 - Benefits are available for an *FDA*-approved drug prescribed for a use that is different from the use for which the *FDA* approved it, when needed for treatment of a Chronic and Seriously Debilitating or Life-Threatening condition. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part

of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding 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 either:

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

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

Life-Threatening - means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

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

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a health condition, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following:

- 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 health condition, 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 health condition, disease or symptoms.

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

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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 Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

Mental Illness - Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care 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 Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

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

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

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

Out-of-Pocket Limit - the maximum amount that you will pay per year which includes the Annual Deductible, Co-payments or Co-insurance (as applicable). The Out-of-Pocket Limit excludes Premiums, balance billing amounts for out-of-Network providers and your spending for non-covered services. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

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

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

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject, from time to time, to our review and change. You may find out which tier a particular Pharmaceutical Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Any acupuncturist, audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist, or other provider who acts within the scope of his or her license will be considered a Physician for purposes of this Policy. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

- Provides a program of treatment.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Note that Benefits for Outpatient Prescription Drugs, 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 Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is established. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the established rate. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by us.

Serious Emotional Disturbances - when a Enrolled Dependent child who has one or more mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the disorder, one or more of the following is true:

- The child is at risk of removal from home or has been ill for more than six months.
- The child displays psychotic features, risk of suicide or risk of violence.
- The child meets special education eligibility requirements under state law.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to you for Covered Health Care Services.

Severe Mental Illness - any of the following diagnosed Severe Mental Illnesses: schizophrenia or schizoaffective disorder, bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or Autism Spectrum Disorders; anorexia nervosa; and bulimia nervosa.

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

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

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

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

Spouse - a person who is married to an Employee. All references to Spouse shall include a Domestic Partner. Please refer to the definition of *Domestic Partner*.

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

Substance-Related and Addictive Disorders Services - Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Telehealth - means the mode of delivering Covered Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Health Care Services are provided via a telecommunications system or where the asynchronous store and forward service originates.

- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Total Disability or Totally Disabled - A disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

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

Triage - Triage is the assessment of your health concerns and symptoms via communication, with a Physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage your need for care, for the purpose of determining the urgency of your need for care. Triage or screening services are available 24 hours per day, 7 days per week.

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

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

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

Please note:

- If you have a Life-Threatening or seriously debilitating condition, an otherwise Unproven Service may be a Covered Health Care Service for that health condition. Prior to such a determination, it must first be established that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that health condition.
- An otherwise Unproven Service may be a Covered Health Care Service if you have a health condition that is not a Life-Threatening or seriously debilitating condition. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.

- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- You must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

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

Urgent Request - any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim for medical care or treatment.
- In determining whether a claim for medical care or treatment involves urgent care, the individual acting on behalf of the plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of your medical condition determines that a claim involves urgent care, the claim for medical care or treatment will be treated as an urgent care claim.

Section 10: Patient Protection and Affordable Care Act (PPACA) Zero Cost Share Preventive Care Medications

Benefits for PPACA Zero Cost Share Preventive Care Medications

Benefits are provided for PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician. Benefits are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance or Annual Deductible). You may determine whether a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Except as specifically described in this section, Benefits under the Policy are not available for prescription drug products for outpatient use.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your PPACA Zero Cost Share Preventive Care Medication at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the PPACA Zero Cost Share Preventive Care Medication at the pharmacy.

You may seek reimbursement from us as described in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the PPACA Zero Cost Share Preventive Care Medication was dispensed.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Springs, AR 71903

Designated Pharmacies

If you require certain PPACA Zero Cost Share Preventive Care Medications, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those PPACA Zero Cost Share Preventive Care Medications.

If you are directed to a Designated Pharmacy and you choose not to obtain your PPACA Zero Cost Share Preventive Care Medication from a Designated Pharmacy, no Benefit will be paid for that PPACA Zero Cost Share Preventive Care Medication.

Rebates and Other Payments

We may receive rebates for certain PPACA Zero Cost Share Preventive Care Medications you purchase. We do not pass these rebates on to you, nor are they applied to any Annual Deductible stated in the *Schedule of Benefits* or taken into account in determining your Co-payments and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers. 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 *PPACA Zero Cost Share Preventive Care Medication* section of the *Certificate*. We are not required to pass on to you, and do not pass on to you, such amounts.

How Do Supply Limits Apply?

Some PPACA Zero Cost Share Preventive Care Medications are subject to 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.

You may determine whether a PPACA Zero Cost Share Preventive Care Medication has been assigned a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Defined Terms

Designated Pharmacy - a pharmacy that has entered into an agreement with us, or with an organization contracting on our behalf, to provide specific PPACA Zero Cost Share Preventive Care Medications. Not all Network Pharmacies are Designated Pharmacies.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Preventive Care Medications to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Preventive Care Medications.
- Been designated by us as a Network Pharmacy.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* including:
- 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*.
- Prescription Drug Products prescribed to prevention conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- All *FDA*-approved contraceptive drugs, devices, and other products for women, including all *FDA*-approved, contraceptive drugs, devices, and products available contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.

- A complete list of Preventive Care Medications covered under the Outpatient Prescription Drug benefit can be found on the Pharmacy Information page of myuhc.com - Go to: myuhc.com > Pharmacy Information > Health Care Reform - Preventive Care Medications.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a PPACA Zero Cost Share Preventive Care Medication dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Order or Refill - the directive to dispense a Preventive Care Medication issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Preventive Care Medication without reference to reimbursement to the pharmacy by third parties. This fee includes a dispensing fee and any applicable sales tax.

Nondiscrimination Notice and Access to Communication Services

UnitedHealthcare Services, Inc. on behalf of itself and its affiliates does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, you can send a complaint to:

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card.

If you think you were treated unfairly because of your race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can also send a complaint to the California Department of Insurance:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (1-800-927-4357)
1-800-482-4833 (TTY)
Internet Web site: www.insurance.ca.gov

If you think you weren't treated unfairly because of your sex, age, race, color, national origin, or disability, you can also file a complaint with the U.S. Dept. of Health and Human services:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼1-800-842-2656

說中文人士將為您提供協助。如需更多協助，請致電保險部熱線1-800-927-4357(Chinese)

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-866-260-2723.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libheng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف الموجود على معرف العضوية. المجاني

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけ
ます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer, Cambodian) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

ՈՒՇԱՐԴՈՒԹՅՈՒՆ՝ Եթե հայերեն (Armenian) եք խոսում, անվճար լեզվալսման օգնություն ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր անձնաչափալսման քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

โปรดทราบ: หากคุณพูดภาษาไทย (Thai) มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่
คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวของคุณ

Clinical Trials Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for clinical trials.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Care Services

Clinical Trials in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

Clinical Trials

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

- Cancer or other Life-Threatening disease or condition.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when you are:

- Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition, or
- Either:
 - the referring health care professional is a participating health care provider and has concluded that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial, or
 - you provide medical and scientific information establishing that your participation in such trial would be appropriate based upon you meeting the conditions that are eligible for the clinical trial.

Routine patient care costs for qualifying clinical trials include:

- With respect to a clinical trial for the treatment of cancer, the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be Covered Health Care Services under the Policy if those drugs, items, devices and services were not provided in connection with for a Covered Person who is not enrolled in an approved clinical trial program.
- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.

- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s), drug, item, or device or service.
 - The clinically appropriate monitoring of the effects of the Experimental or Investigational Service(s), drug, item, or device or service.
 - The prevention of complications arising from the provision of the Experimental or Investigational Service(s), drug, item, or device or service.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Investigational, drug, item, device or service, including the diagnosis of treatment of the complications.

Routine costs for clinical trials do not include:

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

With respect to cancer or other Life-Threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other Life-Threatening disease or condition, including involving a drug that is exempt under federal regulations from a new drug application. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.

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

With respect to a clinical trial for the treatment of cancer or other Life-Threatening disease or condition, Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers. If one or more Network providers are conducting an approved clinical trial, we may require that you participate in the clinical trial through a Network provider if the Network provider accepts you as a clinical trial participant. We may also restrict coverage to an approved clinical trial in the state of California, unless the clinical trial is not offered or available through a Network provider in the state of California.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'William J. Golden', with a stylized, cursive script.

William J Golden, President

Emergency Air Ambulance Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to disclose that Emergency air ambulance services provided by an out-of-Network provider are subject to the same cost sharing required if the services were provided by a Network provider.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Schedule of Benefits

Allowed Amounts in the Schedule of Benefits is replaced with the provision below:

Allowed Amounts

Benefits for Covered Health Care Services are based on Allowed Amounts. Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network facility based Physician (other than Emergency Health Care Services or services otherwise arranged by us), you will be responsible to the out-of-Network facility based Physician for any amount billed that is greater than the amount we calculate to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are calculated in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are calculated, based on:
 - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Allowed Amounts are calculated 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:

- ▶ 50% of *CMS* for the same or similar laboratory service.
- ▶ 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - ▶ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
 - ▶ When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
 - ▶ When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

IMPORTANT NOTICE: Out-of-Network providers at a Network facility may not bill you for any difference between the provider's billed charges and the Allowed Amount described here. Covered Health Care Services for Emergency air ambulance provided by an out-of-Network provider are subject to the same cost sharing required if the services were provided by a Network provider. You will not pay more than the Network cost sharing amount.

For Emergency Health Care Services and Emergency ambulance transportation provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or calculated based upon the greater of:

- The median amount negotiated with Network providers for the same service.
- The amount for the Emergency Health Care Service calculated using the same method used for Out-of-Network Benefits. Please see the provision titled "**For Out-of-Network Benefits, Allowed Amounts are based on either of the following**" under the *Allowed Amounts* section in the *Schedule of Benefits* for additional information.
- The amount that would be paid under Medicare for the Emergency Health Care Service, excluding any Network Co-payment or Co-insurance.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. Covered Health Care Services for Emergency air ambulance provided by an out-of-Network provider are subject to the same cost sharing required if the services were provided by a Network provider. You will not pay more than the Network cost sharing amount.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'W. Golden', with a long horizontal flourish extending to the right.

William J Golden, President

Continuity of Care for Maternal Mental Health Condition Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide continuity of care for an individual who has been diagnosed with a maternal mental health condition.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Schedule of Benefits

Provider Network in the Schedule of Benefits is replaced with the provision below:

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

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 medically appropriate care from a qualified provider cannot be provided within the Network, we will arrange for the required care with an available and accessible out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

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

Continuity of Care

If you are undergoing a course of treatment with a Network provider for one of the medical conditions below, and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's agreement, for continuation of Covered Health Care Services rendered by the terminated provider for the time periods shown below. Co-payments, deductibles or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

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

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a health condition or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Health Care Services will be provided for the duration of the acute condition.
- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, health condition, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health Care Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, in consultation with you and the terminated Network provider and consistent with good professional practice. Completion of Covered Health Care Services under this provision will not exceed 12 months from termination date of the provider's agreement.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Care Services will be provided for the duration of the pregnancy.

For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of Covered Health Care Services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later. For purposes of this section, "maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Care Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement.
- **The care of a newborn child between birth and age 36 months.** Completion of Covered Health Care Services will not exceed 12 months from the termination date of the provider's agreement.
- **Performance of a surgery or other procedure.** Performance of a surgery or other procedure that has been recommended and documented by the Network provider to occur within 180 days of the termination date of the provider's agreement.

This section does not apply to treatment by a provider or provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

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

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'W. Golden', with a stylized, cursive script.

William J Golden, President

Mental Health Care and Substance-Related and Addictive Disorders Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for Mental Health Care and Substance-Related and Addictive Disorders Services.

Because this Amendment reflects changes in requirements of insurance law of the State of California, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Care Services

Gender Dysphoria in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria include the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Care and Substance-Related and Addictive Disorders Services*.
- Cross-sex hormone therapy:
 - Cross-sex hormone therapy administered by a medical provider (for example during an office visit).
 - Cross-sex hormone therapy dispensed from a pharmacy as provided under your *Outpatient Prescription Drug Rider*.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Puberty suppressing hormones, speech therapy and fertility preservation.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Any other reconstructive surgery necessary to create a normal appearance for the gender with which you identify. Non-genital, non-breast interventions shall be covered when determined to be Medically Necessary and not for purely aesthetic reasons.

Mental Health Care and Substance-Related and Addictive Disorders Services in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a Physician acting within the scope of his or her license.

Benefits for Mental Health Care include Covered Health Care Services for the prevention, diagnosis and treatment of Mental Illnesses. Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

Benefits for Medically Necessary Treatment of Mental Health Care and Substance-Related and Addictive Disorder Services will be provided under the same terms and conditions applied to other medical conditions.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Emergency Health Care Services.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Prescription drugs.
- Medication-assisted treatment for Substance-Related and Addictive Disorders Services.
- Office-based medication-assisted opioid treatment, including methadone.
- Medication-assisted opioid treatment programs, including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program.
- Treatment programs at federally certified Methadone clinics.

Coverage determinations relating to Medically Necessary Treatment of Mental Health and Substance-Related and Addictive Disorder Services will be made utilizing the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty area.

Covered Health Care Services for Mental Health Care and Substance-Related and Addictive Disorder Services include basic health care services.

Benefits for Covered Health Care Services provided on an outpatient basis are separated into the following two (2) categories in the Schedule of Benefits for the purpose of establishing the cost share that applies to the Benefit. Examples include, but are not limited to:

- *Outpatient Office Visits:*
 - Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, medication management, office-based medication-assisted opioid treatment, including methadone, and treatment programs at federally certified methadone clinics.
- *All Other Outpatient Treatment:*
 - Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders delivered at home, medication-assisted opioid treatment programs including methadone, provided as part of or separate (stand-alone program) from a facility-based treatment program, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.

All outpatient Benefits for the prevention, diagnosis or treatment of Mental Health Care and Substance-Related and Addictive Disorders Services are Covered Health Care Services under the cost share for *outpatient office visits* or *all other outpatient office visits* as stated in the *Schedule of Benefits* under *Mental Health Care and Substance-Related and Addictive Disorders Services*.

Benefits include Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:

- Based on an asserted need for cognitive or intelligence quotient (IQ) testing;

- On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

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

For non-emergency, out-of-Network, inpatient behavioral health care, prior authorization may be required. If so, you must contact the Mental Health/Substance-Related Addictive Disorders Designee for referrals to providers and coordination of care and failure to obtain prior authorization from the designee will result in a penalty. Please refer to the *Mental Health Care and Substance-Related and Addictive Disorders Services* Benefit category in the Schedule of Benefits for information on the prior authorization requirements and penalty, if applicable.

For all other levels of care, we encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care, but you are not required to do so and you will not be subject to a penalty if you do not.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described under *Section 6: Questions, Complaints and Appeals*. You can call us at the telephone number on your ID card.

Section 2: Exclusions and Limitations

The exclusions in the Certificate under Section 2: Exclusions and Limitations, H. Mental Health Care and Substance-Related and Addictive Disorders are replaced with the following:

1. Services that are not Medically Necessary and are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
2. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act* that are not Medically Necessary. This exclusion will not affect or reduce any obligation to provide services for pervasive developmental disorder or Autism Spectrum Disorders as required by California law.
3. Transitional Living services.

Section 9: Defined Terms

The definition of Medically Necessary in the Certificate under Section 9: Defined Terms is replaced with the following:

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a health condition, disease or its symptoms, that are all of the following:

- 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 health condition, 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 health condition, disease or symptoms.

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

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

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

This definition does not apply to Covered Health Care Services for Mental Health Care and Substance-Related and Addictive Disorders Services. Please see the definition of *Medically Necessary Treatment of Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 9: Defined Terms*.

The following definition of Medically Necessary Treatment of Mental Health Care and Substance-Related Addictive Disorders Services is added to the Certificate under Section 9: Defined Terms:

Medically Necessary Treatment of Mental Health Care and Substance-Related and Addictive Disorders Services - a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating Physician, or other health care provider.
- Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating Physician, or other health care provider.

For the purposes of this definition, "generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidenced-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the *United States Food and Drug Administration*.

The definition of Mental Health Care Services in the Certificate under Section 9: Defined Terms is replaced with the following:

Mental Health Care Services - Covered Health Care Services for the prevention, diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the

International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association.

The definition of Physician in the Certificate under Section 9: Defined Terms is replaced with the following:

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

Any acupuncturist, audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, associate clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, associate marriage and family therapist or marriage and family therapist trainee, associate professional clinical counselor or professional clinical counselor trainee, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychologist assistant, psychology trainee, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist, qualified autism service provider or qualified autism service professional certified by a national entity, or other provider who acts within the scope of his or her license will be considered a Physician for purposes of this Policy. 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.

The definition of Substance-Related and Addictive Disorders Services in the Certificate under Section 9: Defined Terms is replaced with the following:

Substance-Related and Addictive Disorders Services - Services for the prevention, diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.*

The definitions of Serious Emotional Disturbances and Severe Mental Illness in the Certificate under Section 9: Defined Terms are deleted.

Schedule of Benefits

The provision titled "What Will You Pay for Covered Health Care Services?" in the Schedule of Benefits is replaced with the provision below:

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

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

The terms and conditions applied to Benefits for Medically Necessary treatment of Mental Health Care and Substance-Related and Addictive Disorders Services shall be applied equally to all Benefits under the Policy, including but not limited to:

- Maximum and annual lifetime Benefits, if not prohibited by state or federal law.
- Co-payments and Co-insurance.

- Individual and family deductibles.
- Out-of-Pocket Limit.

The provision titled "Access to a Network Provider" in the Schedule of Benefits is replaced with the provision below:

ACCESS TO A NETWORK PROVIDER:

If medically appropriate care from a qualified provider cannot be provided within the network, we will arrange for the required care with an available and accessible Out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

Type of Network Provider	Maximum Travel Distance or Travel Time
Hospital	15 miles or 30 minutes
Primary Care Physician	15 miles or 30 minutes
Specialist	30 miles or 60 minutes
Mental Health Care Services and Substance-Related and Addictive Disorders professionals	15 miles or 30 minutes

Please refer to the "Timely Access to Care" standards below for addition information on access to care.

Timely Access To Care

The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your Physician can request that the appointment be sooner.

Sometimes waiting longer for care is not a problem. Your provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.

In-person appointment wait times:

Urgent Appointments	Wait time
For services that don't need prior authorization	48 hours
For services that do need prior authorization	96 hours
Non-Urgent Appointments	Wait time
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a	10 business days

physician)	
Appointment for other services to diagnose or treat an injury, illness or other health condition	15 business days

Telephone wait times:

You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your ID card.

If you call the number at the back of your ID card, someone should answer the phone within 10 minutes during normal business hours.

UnitedHealthcare Insurance Company



William J Golden, President

Preventive Care Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for preventive care services.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Care Services

Preventive Care Services in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

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 (<https://www.healthcare.gov/coverage/preventive-care-benefits/>):

- 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* (<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>), including:
 - Intensive behavioral counseling interventions for healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease risk factors. Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors. For adults who are overweight or obese (overweight (BMI > 25) or obese (BMI \geq 30)) and have additional CVD risk factors (hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome), 12-26 sessions per year of intensive behavioral counseling interventions to promote a healthful diet and physical activity.
 - Screening for abnormal blood glucose in adults aged 40 to 70 years who are overweight (BMI > 25) or obese (BMI \geq 30). For individuals with abnormal blood glucose, 12-26 sessions per year of intensive behavioral counseling interventions to promote a healthful diet and physical activity.
 - Cancer screening tests and counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions.
 - Screening tests for hereditary breast and ovarian cancer are covered as a preventive care service when they are an "A" or "B" recommendation of the *United States Preventive Services Task Force*.
 - Tobacco use and tobacco-related disease counseling and interventions. For each quit attempt, the following benefits are provided without prior authorization when prescribed:
 - ◆ A minimum of four in-person tobacco cessation counseling sessions (including group counseling and individual counseling), as well as 3 telephone counseling sessions, all of which are at least 10 minutes; AND

- ◆ Self-help materials that are tailored to the individual patient; AND
 - ◆ All *FDA*-approved tobacco cessation medications (including both prescription and over-the-counter medications, and including combining multiple medications) for a minimum of the length of time specified in the product labeling.
 - ◆ There is no limit on the number of tobacco cessation attempts covered during the plan year.
- Aspirin preventive medication: adults aged 50 to 59 years with a $\geq 10\%$ 10-year cardiovascular risk.
 - Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors anastrozole and exemestane.
 - Folic acid supplementation for women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid.
 - Statin preventive medication for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors, and a calculated 10-year cardiovascular disease event risk of 10% or greater.
 - Bowel preparation medications, when medically appropriate and prescribed by a health care provider, are an integral part of the preventive screening colonoscopy, and required to be covered in accordance with the requirements of PHS Act section 2713 and its implementing regulations.
 - Perinatal depression preventive counseling interventions for pregnant and postpartum persons at increased risk of perinatal depression.
 - Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (medications available under the plan's prescription drug Benefit) as well as follow up monitoring including creatinine testing, hepatitis B and C testing, STI testing (chlamydia, gonorrhea and syphilis) and pregnancy testing.
 - Genetic Counseling and Evaluation for BRCA Testing and BRCA Lab Screening.
 - Hepatitis B and C Virus Infection Screening.
 - Screening and behavioral counseling for alcohol use in the primary care setting for all persons.
 - Colorectal cancer screening in adults age 50 - 75, including where necessary, pre-op consultation, bowel preparation medications, anesthesia, polyp removal, and pathology of polyp biopsy.
 - Yearly screening for lung cancer with low-dose computed tomography in adults age 55 - 80 who have 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
 - Behavioral counseling for all persons on the prevention of skin cancer.
 - Screening for depression for all persons.
 - Exercise interventions during a preventive wellness exam or focused office visit for community-dwelling adults age 65 and older at increased risk for falls.
 - Screening and measurement for high blood pressure in adults.
 - Screening and counseling interventions for intimate partner and domestic violence.

- Screening for latent tuberculosis in asymptomatic adults at increased risk of infection.
 - Screening for diabetes in adults age 40 - 70 who are overweight or obese.
 - Screening and antibiotic therapy for asymptomatic bacteriuria in pregnant persons.
 - Screening for gestational diabetes mellitus in pregnant persons.
 - Folic acid supplement for women who are or may become pregnant (medications available under the plan's prescription drug Benefit).
 - Screening for preeclampsia in pregnant persons and low-dose aspirin to prevent preeclampsia during pregnancy (medications available under the plan's prescription drug Benefit).
 - Wellness examination visits for all persons, including prenatal and postnatal care visits.
 - Rh(D) incompatibility screening for pregnant persons include coverage for blood typing and antibody testing, repeated antibody testing, and intervention with Rh(D) immunoglobulin.
 - Chlamydia, gonorrhea, and syphilis screening.
 - Gonococcal ophthalmia neonatorum preventive medication (medications available under the plan's prescription drug Benefit).
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including FDA approved AIDS vaccine if recommended by the *United States Public Health Services* (<https://www.cdc.gov/vaccines/schedules/resource-library/index.html>). Please see CDC immunization schedules at the following websites:

<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>;
<https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>; and
<https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>.
- 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* (<https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html>), including screening for blood lead levels, Phenylketonuria (PKU) testing, periodic health evaluations, and laboratory services in connection with periodic health evaluations. The *Uniform Screening Panel* recommended by the *U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children*.

Benefits are also provided for wellness examinations (well-baby, well-child) in accordance with the *American Academy of Pediatrics* and *American Academy of Family Physicians* age and frequency guidelines and include:
 - Screening newborns for hearing problems, thyroid disease, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases and phenylketonuria screening.
 - For children: Counseling for fluoride for prevention of dental cavities, as well as fluoride application in the primary care setting for children age 0-5 and fluoride supplementation in children through age 16 through the plan's prescription drug benefit; screening for major depressive disorders; visual acuity screening through age 21 and instrument-based screening vision screening through age 5; lead; tuberculosis; developmental disorders/screening and surveillance, as well as, Autism Spectrum Disorders screening through age 2.

- Screening and counseling for obesity in children and adolescents. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including comprehensive, intensive behavioral interventions to promote improvement in weight status. Screening for obesity in children and adolescents beginning at 24 months. For obese children and adolescents ages 6-21, at least 26 -52 contact hours per year of comprehensive, intensive behavioral interventions to promote improvement in weight. Comprehensive means: sessions targeting both the parent and child (separately, together, or both); individual sessions (both family and group); providing information about healthy eating, safe exercising, and reading food labels; encouraging the use of stimulus control (e.g., limiting access to tempting foods and limiting screen time), goal setting, self-monitoring, contingent rewards, and problem solving; and supervised physical activity sessions.

Benefits for preventive care for children will be consistent with both of the following:

- The *Recommendations for Preventive Pediatric Health Care*, as adopted by the *American Academy of Pediatrics* as identified in the *Bright Futures Recommendations for Preventive Pediatric Health Care* (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) which includes BMI screening beginning at 24 months.
- The most current version of the *Recommended Childhood Immunization Schedule/United States*, jointly adopted by the *American Academy of Pediatrics*, the *Advisory Committee on Immunization Practices*, and the *American Academy of Family Physicians*, unless determined otherwise by the *State Department of Health Services*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration Women's Preventive Services Guidelines* (<https://www.hrsa.gov/womens-guidelines-2016/index.html>), including breast cancer screening, annual cervical cancer screening age 21-65, anxiety screening, osteoporosis screening and screening mammography. Benefits for preventive care visits include preconception and prenatal services and compressive lactation support services. Comprehensive lactation support services include counseling, education, and equipment and supplies.
- Covered Health Care Services also include voluntary family planning and all *FDA*-approved contraceptive drugs, devices, and other products for women as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law, including but not limited to the following services:
 - Office visits, examinations, patient education and counseling on contraception (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
 - Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
 - Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
 - Follow-up services related to all *FDA*-approved contraceptive drugs, devices, and other products (including all *FDA*-approved over-the-counter drugs, devices, and other products) for women. Follow-up services include, but are not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
 - Voluntary female sterilization procedures, including surgical sterilization (tubal ligation) and implantable sterilization.

Benefits also include *FDA*-approved contraceptive drugs, devices, and products available over-the-counter when prescribed by a Network provider.

Note: This plan covers up to a 12-month supply of *FDA*-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

- Prescription Drug Products prescribed to prevent conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- *FDA*-approved contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.

A complete list of Preventive Care Medications covered under the Preventive Care Services benefit can be found at www.myuhc.com, under Pharmacy Information. The Preventive Care List is labeled "HCR Preventive Care" on the PDL (Prescription Drug List) used by your plan. Preventive Care Medications can be obtained at Network Pharmacies with a prescription from a Physician.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one hospital grade breast pump and double breast pump kit per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits for a hospital grade breast pump and double breast pump kit are provided taking into account the following determinations:

- Which pump is the most cost effective.
 - Whether the pump should be purchased or rented.
 - Duration of a rental.
 - Timing of purchase or rental.
- With respect to men, additional screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.
 - Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
 - Routine non-pediatric eye exam services for preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
 - Hearing exams to find out the need for hearing correction, for all ages.
 - Screening for obesity in all adults. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including intensive, multicomponent behavioral interventions for Covered Persons with a body mass index (BMI) of 30 kg/m² or higher. For obese adults, 12-26 sessions per year of intensive, multicomponent behavioral interventions for weight management. Multicomponent means: Group and individual sessions of high intensity (12 to 26 sessions in a year); Behavioral management activities, such as weight-loss goals; Improving diet or nutrition and increasing physical activity; Addressing barriers to change; Self-monitoring; and Strategizing how to maintain lifestyle changes.

California mandated preventive health care services:

As required under California law, Benefits under this section include:

- Screening for blood lead levels in children who are at risk for lead poisoning as determined by a health care provider in accordance with standards adopted by the *California Department of Public Health*.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'W. J. Golden', written in a cursive style.

William J Golden, President

Telehealth Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for telehealth services.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Care Services

Telehealth Services in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

Telehealth Services

Benefits are available for Covered Health Care Services received through telehealth. No in-person contact is required between a licensed health care provider and a Covered Person for Covered Health Care Services appropriately provided through telehealth, subject to all terms and conditions of the Policy. Benefits for telehealth services will be on the same basis and to the same extent for Covered Health Care Services for the same service through in-person diagnosis, consultation, or treatment.

Prior to the delivery of Covered Health Care Services via telehealth, the health care provider at the originating site shall verbally inform the Covered Person that telehealth may be used and obtain verbal consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

The appropriate use of telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'William J. Golden', is positioned above the printed name.

William J Golden, President

Consolidated Appropriations Act Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below to comply with the applicable provisions of the *Consolidated Appropriations Act (the "Act")* (P.L. 116-260).

This Amendment reflects requirements of the Act; however, these requirements do not preempt applicable state law.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

No Surprises Act

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- 1) When ancillary services, as described in the Act, are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- 2) When non-ancillary services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria as described in the Act.
- 3) When Emergency health care services are provided by an out-of-Network provider.
- 4) When air ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Except for air ambulance, your cost share is based on the recognized amount as described in the Act and as set forth below. Your cost share for air ambulance is based on the rates that would apply if the service was provided by a Network provider.

When Covered Health Care Services are received from out-of-Network providers as stated above, Allowed Amounts are based upon one of the following as applicable:

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

For the purpose of this Amendment the following terms have the meanings stated below:

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

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;

- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the *Secretary* (as that term is applied in the Act);
- Provided by such other specialty practitioners as determined by the *Secretary*; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

"Emergency health care services" are the following services with respect to an Emergency:

- A medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an independent freestanding emergency department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided).
- Emergency health care services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) Any other conditions as specified by the *Secretary*.

"Independent freestanding emergency department" is a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency health care services

"Recognized amount" is the amount which your cost sharing is based on for the below Covered Health Care Services when provided by out-of-Network providers:

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

The amount is based on one of the following:

- 1) Applicable state law,
- 2) An *All Payer Model Agreement* if adopted, or
- 3) The qualifying payment amount as determined under applicable law.

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

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network provider.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'William J. Golden', written in a cursive style.

William J Golden, President

Home Test Kits for Sexually Transmitted Diseases Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for home test kits for sexually transmitted diseases.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Care Services

The following provision is added to the Certificate, Section 1: Covered Health Care Services:

Home Test Kits for Sexually Transmitted Diseases

Benefits for home test kits for sexually transmitted diseases (STDs), including any laboratory costs for processing the kit, that are Medically Necessary or appropriate and ordered directly by a Network provider, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

"Home test kit" means a product used for a test recommended by the federal *Centers for Disease Control and Prevention* guidelines or the *United States Preventive Services Task Force* that has been waived under the federal *Clinical Laboratory Improvement Act (CLIA)*, FDA-cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

Schedule of Benefits

The provision below for Home Test Kits for Sexually Transmitted Diseases is added to the Schedule of Benefits:

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Home Test Kits for Sexually Transmitted Diseases			
	<p>Network</p> <p>10%</p> <p>Out-of-Network</p>	<p>Yes</p>	<p>Yes</p>

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

UnitedHealthcare Insurance Company



William J Golden, President

Right to Request Confidential Communications Related to Sensitive Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide notice of your right to request confidential communications related to sensitive services amendment.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Your Responsibilities

The following provision is added to the Certificate in the section titled Your Responsibilities:

Exercising your Right to Request Confidential Communications Related to Sensitive Services

You may request that we send confidential communications in a different format or to a different address when the medical information is related to "sensitive services." Sensitive services includes, but is not limited to, all Covered Health Care Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

How we will send confidential communications related to your receipt of sensitive services:

- If you have designated an alternative mailing address, email address, or telephone number, we are required to send or make all communications related to your receipt of sensitive services to the alternative mailing address, email address, or telephone number designated.
- If you have not designated an alternative mailing address, email address, or telephone number, we are required to send or make all communications related to your receipt of sensitive services at the address or telephone number on file.

Types of confidential communications related to your receipt of sensitive services:

The confidential communications subject to this notification include the following written, verbal, or electronic communications related to the receipt of sensitive services:

- bills and attempts to collect payment.
- notices of Adverse Benefit Determinations.
- explanation of benefits (EOB) notice.
- requests for additional information regarding a claim.
- notices of contested claims.
- the name and address of a provider, description of services provided, and other information related to a visit.
- any written, oral, or electronic communication that contains protected health information.

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.

How to submit a confidential communications request:

You can submit a confidential communications request at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

If you have any questions about this notice, please call the telephone number on your ID card.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'William J. Golden', written in a cursive style.

William J Golden, President

Outpatient Prescription Drug UnitedHealthcare Insurance Company Schedule of Benefits

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are available from both Network providers and out-of-Network providers.

Insureds must meet higher deductibles and higher out-of-pocket maximums for out-of-network provider services than for in-network provider services.

DIRECTORY OF NETWORK PROVIDERS

The current directory of Network providers is available online at www.myuhc.com. You may obtain a paper copy of the network provider directory at no cost by contacting us at the telephone number on your ID card.

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

You may contact us or the California Department of Insurance if you have a complaint regarding your ability to access needed health care in a timely manner as described in *IMPORTANT NOTICE - Network Provider Accessibility Complaints* in the *Certificate of Coverage* under *Section 6: Questions, Complaints and Appeals*. Before contacting the California Department of Insurance, please contact us to discuss your complaint.

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357)

1-800-482-4833 (TTY)

You may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Internet Web site: www.insurance.ca.gov**

When Are Benefits Available for Prescription Drug Products?

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

A member who would like to receive Prescription Drug Products prescribed to treat or prevent HIV at any retail Network Pharmacy may opt-out of the Designated Specialty Pharmacy program by contacting us at myuhc.com or the telephone number on your ID card. The cost share for Prescription Drug Products prescribed to treat or prevent HIV that are obtained from any retail Network Pharmacy will be the same as that for Specialty Prescription Drug Products obtained from a Preferred Specialty Network Pharmacy.

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

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product. You or your representative may request an exception to have Benefits for that particular Brand-name Prescription Drug Product continued.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

Note: This plan covers up to a 12-month supply of *FDA*-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Self-administered hormonal contraceptives are covered under the *Outpatient Prescription Drug Rider*.

Partial Fills of Schedule II Controlled Substances

A pharmacist located in California may dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber when dispensed by a California pharmacist.

Beginning January 1, 2019, we will prorate your cost share for a partial fill of a prescription of an oral, solid dosage form of a Schedule II Controlled Substance.

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to find out whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can confirm whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Certain Prescription Drug Products may be subject to Prior Authorization due to the following:

- they contain (an) active ingredient(s) available in and Therapeutically Equivalent (refer to the Outpatient Prescription Drug Rider) to another covered Prescription Drug Product;
- they contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent (refer to the Outpatient Prescription Drug Rider) to another covered Prescription Drug Product; or
- there are Therapeutically Equivalent (refer to the Outpatient Prescription Drug Rider) alternatives available.

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.

Insurers must use the Prescription Drug Prior Authorization Request Form that is prescribed in California regulation or the electronic prior authorization process described in section 10123.191(e). CIC § 10123.191(a); 10 CCR § 2218.30.

To request Prior Authorization, call the number on the back of your ID card. OptumRx will then contact your provider and request the clinical information needed to initiate the review.

If we fail to respond within 72 hours for non-urgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization request from a prescribing provider, the prior authorization request shall be deemed to have been granted.

Exigent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary drug.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the

Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided if the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described in the *Certificate of Coverage* under *Section 6: Questions, Complaints and Appeals*. You may also call the telephone number on your ID card.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

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

Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating your condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate.

If your Physician determines that a Prescription Drug Product or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating your condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com.

If you are changing policies, we will not require you to repeat step therapy when you are already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for your medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for your medical condition.

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

A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in *Prior Authorization Requirements* of this *Outpatient Prescription Drug Schedule of Benefits*.

If we fail to respond within 72 hours for non-urgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed step therapy exception request from a prescribing provider, the step therapy exception request shall be deemed to have been granted. Exigent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary drug.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of you getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Health Care Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services.

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.
2. Agree and provide written consent to participate in IMR.
3. The CDI determines if the request is eligible for IMR.
4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to you, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.
6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify you and us. The decision is binding on UnitedHealthcare Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Health Care Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Insurance:

You may contact the California Department of Insurance for information on the independent external review program by calling:

- 1-800-927 HELP (1-800-927-4357)
- 213-897-8921 1-800-482-4833 (TTY)

You may also write the California Department of Insurance at:

California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

**Please note that a complaint/IMR request can be submitted online at this internet web site:
www.insurance.ca.gov**

Your Right to Request a Drug That Is Not on the Prescription Drug List (PDL)

When a Prescription Drug Product is not on the PDL, you or your representative may request an exception to gain access to that 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 of receipt.

- **In the case of a standard exception request**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. When we grant a standard exception request, we will provide coverage of the Prescription Drug Product for the duration of the prescription, including refills.
- **In the case of an expedited exception request based on exigent circumstances**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. When we grant an exception based on exigent circumstances, we will provide coverage of the Prescription Drug Product (including refills) for the duration of the exigency. Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when the Covered Person is undergoing a current course of treatment using a Prescription Drug Product that is not on the Prescription Drug List (PDL).
- Per CIC § 10123.191(b) of the California Insurance Code, if the insurer fails to respond to the prescribing provider within the prescribed time limits, the request is deemed granted.
- If a Prescription Drug Product is covered pursuant to an exception request, including non-formulary Brand-name, Generic and Specialty Prescription Drug Products, it will be assigned to either tier 3 or tier 4. Tier 4 coverage applies if the Prescription Drug Product meets the criteria for tier 4 as outlined in Coverage Policies and Guidelines, otherwise coverage will be provided on tier 3.

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 of receipt.

External Review

If you are not satisfied with our determination of your exception request, you may 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 of receipt.

Expedited External Review

If you are not satisfied with our determination of your 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 of receipt.

What Do You Pay?

We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, including *FDA*-approved contraceptive drugs, devices and products available when prescribed by a Network provider.

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

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. However, any amount you pay will apply to your maximum out of pocket (MOOP). You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
<p>Co-payment</p> <p>Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount.</p> <p>Co-insurance</p> <p>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.</p> <p>Co-payment and Co-insurance</p> <p>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, including <i>FDA</i>-approved contraceptive drugs, devices and products available when prescribed by a Network provider.</p>

Payment Term And Description	Amounts
<p>number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Co-payment/Co-insurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.</p> <p>NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.</p>	

Benefit Information

<p>The amounts you are required to pay as shown below in the <i>Outpatient Prescription Drug Schedule of Benefits</i> are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.</p>	
<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay?</p> <p>This May Include a Co-payment, Co-insurance or Both</p>
<p>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 Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement.</p> <p>For oral chemotherapeutic agents on any tier, the total amount of Co-payments and/or Co-insurance shall not exceed \$200 for an individual prescription of up to a 30-day supply.</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. Up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive if you pay a Co-payment and/or Co-insurance for each cycle supplied. 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$20.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$40.00 per Prescription Order or Refill. However, you will not pay more</p>

<p>The amounts you are required to pay as shown below in the <i>Outpatient Prescription Drug Schedule of Benefits</i> are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.</p>	
<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay?</p> <p>This May Include a Co-payment, Co-insurance or Both</p>
<p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p>	<p>than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$75.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any tier, the total amount of Co-payments and/or Co-insurance shall not exceed \$200 for an individual prescription of up to a 30-day supply.</p>
<p>PPACA Zero Cost Share Preventive Care Medications from a Retail Network Pharmacy</p>	
<p>Benefits are provided for PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy as required by applicable law under any of the following:</p> <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the <i>United States Preventive Services Task Force</i>. • With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the <i>Health Resources and Services Administration</i>. • With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the <i>Health</i> 	<p>No Copayment or Co-Insurance required.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p><i>Resources and Services Administration.</i></p> <ul style="list-style-type: none"> • Prescription Drug Products prescribed to prevention conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills). • All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices and products available over the counter. Contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel. <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. • Up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive. 	
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply:	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<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. Up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive if you pay a Co-payment and/or Co-insurance 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 Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p>	<p>Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: 20% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 20% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 20% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any tier, the total amount of Co-payments and/or Co-insurance shall not exceed \$200 for an individual prescription of up to a 30-day supply.</p>
<p>Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty</i> 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For up to a 90-day supply, you pay:</p> <p>For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$50.00 per Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$100.00 per</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p><i>Prescription Drug Products.</i></p> <p>We may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Co-payment and/or Co-insurance you would pay at a retail Network Pharmacy. You may find out whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Co-payment and/or Co-insurance for any Prescription Orders or Refills sent to the mail order pharmacy or Preferred 90 Day Retail Network 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>Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$187.50 per Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any tier, the total amount of Co-payments and/or Co-insurance shall not exceed \$200 for an individual prescription of up to a 30-day supply.</p>

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

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

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'William J. Golden', with a stylized, cursive script.

William J Golden, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places *FDA*-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

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 out-of-Network Benefit for that Prescription Drug Product.

A member who would like to receive Prescription Drug Products prescribed to treat or prevent HIV at any retail Network Pharmacy may opt-out of the Designated Specialty Pharmacy program by contacting us at myuhc.com or the telephone number on your ID card. The cost share for Prescription Drug Products prescribed to treat or prevent HIV that are obtained from any retail Network Pharmacy will be the same as that for Specialty Prescription Drug Products obtained from a Preferred Specialty Network Pharmacy.

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

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

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you

will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

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

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products.....	20
Section 2: Exclusions.....	25
Section 3: Defined Terms.....	28

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

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

Benefits include coverage for insulin, prescription drugs for diabetes, and glucagon. Additional diabetic supplies covered are the following:

- standard insulin syringes with needles;
- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices; and
- glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *Certificate*.

Note: All medically necessary drugs are covered, including drugs that are not listed on the Prescription Drug List (PDL) when medically necessary.

Note: This plan covers up to a 12-month supply of *FDA*-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Self-administered hormonal contraceptives are covered under the Outpatient Prescription Drug Rider.

- Prescription Drug Products prescribed to prevent conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- All *FDA*-approved contraceptive drugs, devices, and other products for women, including all *FDA*-approved, contraceptive drugs, devices, and products available over the counter. Contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.
- All *FDA*-approved antiretroviral single tablet regimen drugs for HIV.
- A complete list of PPACA Zero Cost Share Preventive Care Medications covered under the Outpatient Prescription Drug benefit can be found at myuhc.com, under Pharmacy Information. The Preventive Care List is labeled "HCR Preventive Care" on the PDL (Prescription Drug List) used by your plan. PPACA Zero Cost Share Preventive Care Medications can be obtained, free of charge, at Network Pharmacies with a prescription from a Physician.
- All *FDA*-approved tobacco cessation medications (including both prescription and over-the-counter medications, and including combining multiple medications) for a minimum of the length of time specified in the *Agency for Healthcare Research and Quality's (AHRQ) "Suggestions for the Clinical Use of Medications for Tobacco Dependence Treatment."*

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 out-of-Network Benefit for that Specialty Prescription Drug Product.

A member who would like to receive Prescription Drug Products prescribed to treat or prevent HIV at any retail Network Pharmacy may opt-out of the Designated Specialty Pharmacy program by contacting us at myuhc.com or the telephone number on your ID card. The cost share for Prescription Drug Products prescribed to treat or prevent HIV that are obtained from any retail Network Pharmacy will be the same as that for Specialty Prescription Drug Products obtained from a Preferred Specialty Network Pharmacy.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

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

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Your Right to Request Coverage for a Prescription Drug Product Not Included on the Prescription Drug List (PDL)

When a Prescription Drug Product is not included on your plan's Prescription Drug List (PDL), you or your representative may request an exception to gain access to coverage of that 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 of our receipt.

- **In the case of a standard exception request**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. When we grant a standard exception request, we will provide coverage of the Prescription Drug Product for the duration of the prescription, including refills.
- **In the case of an expedited exception request based on exigent circumstances**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. When we grant an exception based on exigent circumstances, we will provide coverage of the Prescription Drug Product (including refills) for the duration of the exigency. Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when the Covered Person is undergoing a current course of treatment using a Prescription Drug Product that is not on the Prescription Drug List (PDL).
- Per CIC § 10123.191(b) of the California Insurance Code, if the insurer fails to respond to the prescribing provider within the prescribed time limits, the request is deemed granted.
- If a Prescription Drug Product is covered pursuant to an exception request, including non-formulary Brand-name, Generic and Specialty Prescription Drug Products, it will be assigned to either tier 3 or tier 4. Tier 4 coverage applies if the Prescription Drug Product meets the criteria for tier 4 as outlined in Coverage Policies and Guidelines, otherwise coverage will be provided on tier 3.

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 of our receipt.

External Review

If you are not satisfied with our determination of your request, you may 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 of receipt.

Expedited External Review

If you are not satisfied with our determination of your 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 of receipt.

Per CIC § 10123.191(b) of the California Insurance Code, if the insurer fails to respond to the prescribing provider within the prescribed time limits, the request is deemed granted.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of you getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Health Care Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services.

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application or access the IMR form online:
<https://www.insurance.ca.gov>.
2. Agree and provide written consent to participate in IMR.
3. The CDI determines if the request is eligible for IMR.
4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to you, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.
6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify you and us. The decision is binding on UnitedHealthcare Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Health Care Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Insurance:

You may contact the California Department of Insurance for information on the independent external review program by calling:

- 1-800-927-HELP (1-800-927-4357)
- 1-800-482-4833 (TTY)

You may also write the California Department of Insurance at:

California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013
Internet Web site: <http://www.insurance.ca.gov>

Section 2: Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens that are Experimental, Investigational or Unproven. This exclusion does not apply to Prescription Drug Products which are prescribed for an indication not approved by the *United States Food and Drug Administration (FDA)* if:
 - (1) The drug is approved by the *FDA*.
 - (2)(A) The drug is prescribed by a contracting licensed health care professional for the treatment of a Life-Threatening condition or

(B) The drug is prescribed by a contracting licensed health care professional for the treatment of a Chronic and Seriously Debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the insurer's formulary, if any.
 - (3) The drug has been recognized for treatment of that condition for any of the following:
 - (A) *The American Hospital Formulary Service's Drug Information*.
 - (B) One of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapeutic regimen.
 - (i) *The Elsevier Gold Standard's Clinical Pharmacology*.
 - (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*.
 - (iii) *The Thompson Micromedex DrugDex*.
 - (C) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Nothing in this section prohibit us from use of a formulary, Co-payments or Co-insurance, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the *FDA*.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare).
6. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement.

7. Any product dispensed for the purpose of appetite suppression or weight loss. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of obesity.
8. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.

This exclusion does not apply to vitamins that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* that are required to be covered under the *Patient Protection and Affordable Care Act (PPACA)*.

11. Unit dose packaging or repackagers of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, that do not meet the definition of a Covered Health Care Service unless Medically Necessary.
14. Prescription Drug Products as a replacement for a previously received Prescription Drug Product that was subsequently lost, stolen, broken or destroyed.
15. Prescription Drug Products when prescribed to treat infertility.
16. Treatment for toenail Onychomycosis (toenail fungus) unless medically necessary.
17. 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. Such determinations may be made up to six times during a calendar year. This means that if an over the counter drug becomes available, we may change the tier in which the drug is placed. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation. This exclusion does not apply to prescribed *FDA*-approved contraceptives or medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
18. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of a health condition, except as described under *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services*.
19. Drug products not approved by the *FDA* that contain marijuana, including medical marijuana.
20. Dental products, including but not limited to prescription fluoride topicals.
21. Diagnostic kits and products.

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

Section 3: Defined Terms

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

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Chronic and Seriously Debilitating - For purposes of the section of California law CIC 10123.195 regarding use of off-label drugs, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

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

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

Life-Threatening - For purposes of the section of California law CIC 10123.195 regarding use of off-label drugs, "Life-Threatening" means either or both of the following:

(1) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(2) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- 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*.
- Prescription Drug Products prescribed to prevention conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices and products available over the counter. Contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

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

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill.

A Prescription Drug Product includes a drug approved by the *U.S. Food and Drug Administration*, which is prescribed for a use that is different from the use for which the *U.S. Food and Drug Administration* approved it, when needed for treatment of a Chronic and Seriously Debilitating or Life-Threatening condition. The drug must be recognized for the specific treatment for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Microdex DrugDex*; or (3) it is recommended by two articles from major peer reviewed medical journals. Benefits will also include

Medically Necessary Covered Health Care Services associated with the administration of a drug subject to the conditions of this Policy.

A Prescription Drug Product includes a drug approved by the *U.S. Food and Drug Administration* prescribed to treat cancer during certain clinical trials as described in the *Certificate of Coverage*.

A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *Certificate*.
 - Disposable devices which are Medically Necessary for the administration of a covered outpatient Prescription Drug Product.
 - A Prescription Drug Product includes all *FDA*- approved contraceptives that are prescribed for a purpose other than preventing conception.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include orally administered anticancer medications used to kill or slow the growth of cancerous cells. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Zero Cost Share Medications Addendum

UnitedHealthcare Insurance Company

As described in this addendum, certain Prescription Drug Products as described in the *Outpatient Prescription Drug Rider* and *Outpatient Prescription Drug Schedule of Benefits* are modified as stated below.

Because this addendum is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*, in the *Outpatient Prescription Drug Rider* in *Section 3: Defined Terms*, and in this addendum below.

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*.

Zero Cost Share Medications

You may obtain up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy up to a consecutive 90-day supply.

You are not responsible for paying any applicable deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

The following definition is added to **Section 3: Defined Terms** in the **Outpatient Prescription Drug Rider**:

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you). You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

UnitedHealthcare Insurance Company



William J Golden, President

Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

When a state law or regulation either makes the Covered Health Care Service unavailable in the Covered Person's state of residence or prohibits the provider from providing the Covered Service, this Rider to the Policy provides a Covered Person with a travel and lodging allowance to receive the Covered Service in another state as legally permissible.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

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

Travel and Lodging Program

The *Travel and Lodging Program* provides support for the Covered Person under the Policy as described above. The program provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Service.

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

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

UnitedHealthcare Insurance Company



William J Golden, President

UnitedHealthcare Insurance Company

Expatriate Insurance Rider

This Rider to the Policy provides Benefits for Covered Health Care Services that are provided outside the *United States*, to Subscribers who are Expatriates or Key Local Nationals and to their Enrolled Dependents. Any reference in this Rider to coverage provided outside the *United States* includes coverage provided in *United States* territories. This Rider, issued with the *Certificate of Coverage (Certificate)*, provides an Expatriate product that provides both *United States* domestic coverage, as described in the *Certificate*, and international coverage, as described in this Rider.

International Benefits

We will pay Benefits for Covered Health Care Services provided by or under the direction of a Physician to Subscribers who are Expatriates or Key Local Nationals and to their Enrolled Dependents. An Expatriate is an Eligible Person who is sent on assignment outside his or her own country, as agreed upon between the Group and us. A Key Local National is an Eligible Person that works and resides within their country of citizenship and who the Group has determined is eligible under the Policy as a condition of their employment and/or because they are essential to the management of their work country's operation.

Does Prior Authorization Apply?

When you choose to receive certain Covered Health Care Services from international providers, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

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

Covered Health Care Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the in this Rider to find out how far in advance you must obtain prior authorization.

- Emergency evacuation.
- Emergency family reunion.
- Medical repatriation.
- Repatriation of remains.
- Transplants.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from international providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may

not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid. If you have a question regarding a determination of whether a service is Medically Necessary, call the telephone number on your ID card. If you disagree with a determination of whether a service is Medically Necessary, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the *Certificate of Coverage*. You may also call the telephone number on your ID card.

Benefits - What You Will Pay for Covered Health Care Services?

International Benefits are provided under this Rider for the Covered Health Care Services shown below in this Rider and as described in more detail in the *Certificate* under *Section 1: Covered Health Care Services*. International Benefits are subject to all other terms, conditions, exclusions and limitations of the Policy, *Certificate* and *Schedule of Benefits* unless otherwise modified by this Rider.

Annual Deductibles are calculated on a calendar year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The total of the Allowed Amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are calculated appear at the end of this Rider.</p>	<p><i>International Benefits</i></p> <p>No Annual Deductible.</p>
Out-of-Pocket Limit	
<p>The maximum you pay per year for Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.</p> <p>The Out-of-Pocket Limit does not include any of the following and once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain 	<p><i>International Benefits</i></p> <p>\$2,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>An individual's payment toward the Out-of-Pocket Limit is limited to the \$2,000 per Covered Person Out-of-Pocket Limit amount stated above. After an individual meets this Out-of-Pocket Limit amount, the Covered</p>

Payment Term And Description	Amounts
<p>prior authorization as required.</p> <ul style="list-style-type: none"> • Charges that exceed Allowed Amounts. • Co-payments or Co-insurance for any Covered Health Care Service shown in this Rider that does not apply to the Out-of-Pocket Limit. 	<p>Person is no longer responsible for cost sharing for the rest of the year.</p>
<p>Co-payment</p>	
<p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount. <p>Details about the way in which Allowed Amounts are calculated appear at the end of this Rider.</p>	
<p>Co-insurance</p>	
<p>Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are calculated appear at the end of this Rider.</p>	

When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits, and any attached Riders and Amendments, unless specifically stated otherwise.

Please refer to Section 1: Covered Health Care Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?	
Acupuncture Services				
Limited to 25 treatments per year.	<i>International</i> None	Yes	Yes	
Ambulance Services				
Emergency Ambulance	<i>International</i> <i>Ground Ambulance</i> 10%	Yes	No	
	<i>Air Ambulance</i> 10%	Yes	No	
	Non-Emergency Ambulance Ground or air ambulance.	<i>International</i> <i>Ground Ambulance</i> 10%	Yes	No
		<i>Air Ambulance</i> 10%	Yes	No
Clinical Trials				

To be a qualifying clinical trial for services outside the *United States*, a clinical trial must meet all of the following criteria:

<ul style="list-style-type: none"> The clinical trial must be situated in the country in which you physically reside. The clinical trial must be sponsored by an entity or government agency that has been designated by the government of the country of assignment, or otherwise authorized by applicable law to sponsor or conduct clinical trials. The clinical trial must satisfy all legal and/or regulatory requirements of the country of assignment necessary to conduct a clinical trial in the country of assignment. The clinical trial must be conducted pursuant to the oversight of an independent ethical committee (<i>IEC</i>), defined as a review panel that is responsible for ensuring the protection of the rights, safety, and well-being of human subjects involved in a clinical investigation and is adequately constituted to provide assurance of that protection. The clinical trial must be conducted in compliance with the <i>United States Food and Drug Administration's (FDA) Good Clinical Practice (GCP)</i> regulations. The subject or purpose of the trial must be the review of an item or service that meets the definition of a Covered Health Care Service and is not excluded under the Policy. 			
	<p>International</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Rider.</p>		
Congenital Heart Disease (CHD) Surgeries			
Benefits include only inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this Rider.	International 10%	Yes	No
Dental Services - Accident Only			
	International 10%	Yes	No
Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	<p>International</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this Rider.</p>		

Diabetes Treatment			
<p>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</p> <p>Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.</p>	<p>International</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Rider.</p> <p>For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i>.</p> <p>Benefits for diabetes supplies will be the same as those stated under the <i>Outpatient Prescription Drug Benefit</i>.</p>		
Durable Medical Equipment (DME), Orthotics and Supplies			
<p>Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase.</p> <p>This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years.</p>	<p>International</p> <p>10%</p>	<p>Yes</p>	<p>No</p>
Emergency Health Care Services - Outpatient			
	<p>International</p> <p>None</p>	<p>Yes</p>	<p>No</p>
Gender Dysphoria			
	<p>International</p> <p><i>Inpatient</i></p> <p>10%</p>	<p>Yes</p>	<p>No</p>

<ul style="list-style-type: none"> Cognitive therapy. <p>For the above outpatient therapies: Limits will be the same as, and combined with, those stated under <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i></p>			
Hearing Aids			
<p>Limited to \$5,000 every year.</p> <p>Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</p>	<p>International</p> <p>10%</p>	Yes	No
Home Health Care			
<p>Limited to 120 visits per year. One visit equals up to four hours of skilled care services.</p> <p>This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p>	<p>International</p> <p>10%</p>	Yes	No
Hospice Care			
	<p>International</p> <p>10%</p>	Yes	No
Hospital - Inpatient Stay			
	<p>International</p> <p>10%</p>	Yes	No
Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient	<p>International</p> <p>None</p>	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	<p>International</p> <p>None</p>	Yes	No

Major Diagnostic and Imaging - Outpatient			
	<i>International</i> 10%	Yes	No
Mental Health Care and Substance-Related and Addictive Disorders Services			
<p><i>Outpatient Office Visits</i> include:</p> <ul style="list-style-type: none"> Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, medication management, office-based medication-assisted opioid treatment, including methadone and treatment programs at federally qualified methadone clinics. <p><i>All Other Outpatient Office Visits</i> include but not limited to:</p> <ul style="list-style-type: none"> Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders delivered at home, medication-assisted opioid treatment programs including methadone provided as part of or separate (stand-alone program) from a facility-based treatment program, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits. 	<p><i>International Inpatient</i> 10%</p> <p><i>Outpatient Office Visits</i> None</p> <p><i>All Other Outpatient Office Visits</i> 10%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p>

Obesity - Weight Loss Surgery			
<p>It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you. These programs are in addition to the Benefits available for <i>Obesity - Weight Loss Surgery</i>. You may call <i>Customer Care</i> at the telephone number on your ID card for information regarding these programs.</p>			
	International		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Rider.		
Ostomy Supplies			
	International		
	10%	Yes	No
Pharmaceutical Products - Outpatient			
Up to a 12-month supply of <i>FDA</i> -approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an insured by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies if you pay a Co-payment and/or Co-insurance for each cycle supplied.	International		
	10%	Yes	No
Physician Fees for Surgical and Medical Services			
	International		
	10%	Yes	No
Physician's Office Services			
In addition to the office visit Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office:	International		
<ul style="list-style-type: none"> Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging -</i> 	None	Yes	No

<p><i>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> 			
Pregnancy - Maternity Services			
<p>We encourage you to notify us regarding your Pregnancy; however, prior notification is not required. 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. These programs are in addition to prenatal and other maternity benefits that are available to you. You may call <i>Customer Care</i> at the telephone number on your ID card for information regarding these programs.</p>			
	<p><i>International</i> Benefits will be the same as those stated under each Covered Health Care Service category in this Rider.</p>		
Preventive Care Services			
Physician office services	<p><i>International</i> None</p>	Yes	No
Prosthetic Devices			
	<p><i>International</i> 10%</p>	Yes	No
Reconstructive Procedures			
	<p><i>International</i> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under</p>		

	each Covered Health Care Service category in this Rider.		
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: <ul style="list-style-type: none"> • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 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. 	International None	Yes	No
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	International 10%	Yes	No
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 120 days per year.	International 10%	Yes	No
Surgery - Outpatient			
	International 10%	Yes	No
Temporomandibular Joint (TMJ) Services			
	International Depending upon where the Covered Health Care Service is		

	provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Rider.		
Therapeutic Treatments - Outpatient			
	<i>International</i> 10%	Yes	No
Urgent Care Center Services			
In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: <ul style="list-style-type: none"> Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<i>International</i> None	Yes	No
Virtual Visits			
	<i>International</i> None	Yes	No
Vision Exams			
Limited to 1 exam every 12 months.	<i>International</i> None	Yes	No

Wigs			
Limited to a maximum reimbursement of \$600 every 24 months.	International 10%	Yes	No

In addition to the Covered Health Care Services described in the *Certificate* in *Section 1: Covered Health Care Services* and described above, International Benefits are available for the Covered Health Care Services described below.

Culturally-Based Services

Services provided that show the medical standards of the country and outlined by the *Ministry of Health* or equivalent authority in which the service is provided, but which may be considered alternative treatments when provided within the *United States*. Benefits for culturally-based services are available only when we determine that the service or supply meets the following criteria:

- It is care or treatment that is as likely to produce a positive outcome as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the health condition involved and your overall health condition.
- It is a diagnostic procedure indicated by the health status of the person that is as likely to result in information that could affect the course of treatment as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the health condition involved and your overall health condition.
- It is diagnosis, care and treatment that is no more costly than any alternative services or supply to meet the above tests, taking into account all health expenses incurred in connection with the service or supply.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does Annual Deductible Apply?
Culturally-Based Services			
	International 10%	Yes	No

Emergency Evacuation

If you suffer a health condition and adequate medical facilities are not available locally in the opinion of the attending Physician or our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary.

Covered Health Care Services include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies necessarily incurred in connection with the emergency evacuation.

Benefits for emergency evacuation are only available if all arrangements for your evacuation are approved in advance and arranged by us.

If you notify us of the need for an evacuation in advance, and in the opinion of our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction, adequate medical facilities are not available locally, but time constraints necessitate the use of a travel agency or vendor not approved by us, we will pay for the evacuation up to the dollar value of what we would have paid using an approved vendor, using the vessel and personnel we would have used, to take you to the nearest facility that we would have deemed capable of providing adequate care.

Includes:

- Transportation of your children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.
- A per diem to cover living expenses for the immediate family members and children accompanying the Covered Person at the evacuation destination.

We will pay for your immediate family members and children (under the age of 18) to return to where you were evacuated from travel. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment for which you were evacuated. All references to an immediate family member will include a Domestic Partner.

Benefits are only provided if there is a reasonable need for you to be accompanied. For the purposes of this Benefit the term "reasonable need" means that you need someone to accompany you for one of more of the following reasons:

- You need assistance to board or disembark from transport,
- You need to be transferred a long distance (at least 500 miles or 800 kilometers),
- There is no medical escort, or
- In the case of a serious acute illness.

There is no coverage for someone to travel with you when the evacuation is for you to receive outpatient treatment such as advanced imaging, radiotherapy, or chemotherapy.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does Annual Deductible Apply?
Emergency Evacuation			
Prior Authorization Requirement			
You must obtain prior authorization as soon as the possibility of Emergency Evacuation arises. If you do not obtain prior authorization, you will be responsible for paying all charges and no Benefits will be			

paid.			
Limited to a per diem of \$300 for up to 30 days towards the living expenses incurred by the persons accompanying you.	<i>International</i> None	Yes	No

Emergency Family Reunion

In the event that you are hospitalized for more than 7 days, or you have received a short-term terminal diagnosis, Benefits are available to transport your immediate family members to join you. Benefits include roundtrip travel and living expenses. All arrangements must be made by us in order to receive this Benefit. All references to an immediate family member will include a Domestic Partner.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does Annual Deductible Apply?
Emergency Family Reunion			
Prior Authorization Requirement			
You must obtain prior authorization as soon as the possibility of emergency family reunion Benefits arises. If you do not obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.			
Limited to a per diem for living expenses for immediate family members of \$300 while the Covered Person is hospitalized up to 30 days	<i>International</i> None	Yes	No

Medical Repatriation

After you receive initial treatment and stabilization for a health condition, if the attending Physician and our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction determines that it is appropriate to facilitate your recovery, we will transport you back to your specified country of nationality, as given on your application form, or your specified country of residence for further medical treatment or to recover. The timing and method of transportation will be determined solely by us and will be suitable to fit your medical needs. Covered Health Care Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Benefits are available for medical repatriation, provided that the treatment required is a Covered Health Care Service.

Benefits for medical repatriation are only available if all arrangements for your repatriation are approved in advance and arranged by us.

Benefits are also provided to return your immediate adult family members and children under the age of eighteen (18) to your specified country of nationality, as given on your application form, or your specified

country of residence if authorized in advance of the repatriation. We will pay for roundtrip travel or other transportation means that we deem appropriate, and the travel must occur at the same time as your repatriation. All arrangements must be made by us in order to receive this Benefit, and we reserve the right to utilize any value you have on existing tickets or ask that your Immediate adult family member serve as a non-medical escort if needed. All references to an immediate adult family member will include a Domestic Partner.

Benefits are only provided if there is a reasonable need for you to be accompanied. For the purposes of this Benefit the term "reasonable need" means that you need someone to accompany you for one or more of the following reasons:

- You need assistance to board or disembark from transport;
- You need to be transferred a long distance (at least 500 miles or 800 kilometers);
- There is no medical escort; or
- In the case of a serious acute illness.

There is no coverage for someone to travel with you when the transfer is for you to receive outpatient treatment such as advanced imaging, radiotherapy, or chemotherapy.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does Annual Deductible Apply?
Medical Repatriation			
Prior Authorization Requirement			
You must obtain prior authorization to obtain Benefits for medical repatriation. If you do not obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.			
	<i>International</i>		
	None	Yes	No

Outpatient Prescription Drugs

Benefits for outpatient prescription drugs that are prescribed for you by your Physician to treat a health condition for which Benefits are provided as described in this Rider. Benefits for outpatient prescription drug products are available when the outpatient prescription drug product meets the definition of a Covered Health Care Service. Benefits are not available for over-the-counter drugs or other drugs or treatments available without a prescription. Prescriptions must be paid for out-of-pocket by the Covered Person and submitted to us for reimbursement.

Benefits provided within the *United States* are provided as described in your *Outpatient Prescription Drug Rider*.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are
--

responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-Payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Outpatient Prescription Drugs			
	<i>International</i> 10%	Yes	No

Repatriation of Remains

In the event of your death, we or our affiliate or authorized vendor will provide for assistance and return of your mortal remains to your specified country of nationality or to your specified country of residence. Services include:

- Designation of a sending funeral home.
- Transportation of the body from the site of death to the sending funeral home.
- Preparation of the remains for either burial or cremation.
- Transportation of the remains from the funeral home to the airport.
- Minimally necessary casket or air tray for transport.
- Coordination of consular services (in the case of death overseas).
- Procuring death certificates.
- Transport of the remains from the airport to the receiving funeral home.

Other services that may be performed include:

- Making travel arrangements for any traveling companions;
- Identifying and/or notifying next-of-kin; and
- Making statutory arrangements such as cremation and urn or embalming and a zinc coffin only if this is required by the airline authorities to carry out the transportation.

Benefits for repatriation of remains are only available if services are approved in advance and arranged by us.

Benefits are also provided to return your immediate adult family members and children under the age of eighteen (18) to your specified country of nationality or to your specified country of residence, if authorized in advance of the repatriation. We will pay for roundtrip travel, and the travel must occur at the same time as your repatriation. All arrangements must be made by us in order to receive this Benefit, and we reserve the right to utilize any value you have on existing tickets or ask that your immediate adult family member serve as a non-medical escort if needed. All references to an immediate adult family member will include a Domestic Partner.

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this Rider will tell you when you are

responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Must You Meet Annual Deductible?
Repatriation of Remains			
Prior Authorization Requirement			
You must obtain prior authorization to obtain Benefits for Repatriation of Remains. If you do not obtain prior authorization, you will be responsible for paying all charges and no Benefits will be paid.			
	<i>International</i> None	Yes	No

Vision Materials

Benefits are provided for the following vision materials:

- Eyeglass lenses that are placed, in eyeglass frames and worn on the face to correct visual acuity limitations.
- Eyeglass frames which mean a structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.
- Contact lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include contact lenses necessary, as determined by your vision care provider, for any of the following:
 - Keratoconus.
 - Anisometropia.
 - Irregular corneal/astigmatism.
 - Aphakia.
 - Facial deformity.
 - Corneal deformity
 - Pathological Myopia.
 - Aniridia.
 - Aniseikonia.
 - Post-traumatic disorders.

Benefits include the fitting/evaluation fees and contacts.

Benefits for vision materials are a percentage of the provider's billed charge.

Vision Materials Reimbursement

When you obtain vision material from a 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 below. Reimbursement will be limited to the amounts stated below in this Rider.

To file a claim for reimbursement for vision material provided by a vision care provider, you must give us all of the following information:

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

Amounts which you are required to pay as shown below in this Rider are based on Allowed Amounts. The <i>Allowed Amounts</i> provision near the end of this Rider will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Must You Meet Annual Deductible?
Vision Materials			
<p><i>Eyeglass Frames and Eyeglass Lenses or Contact Lenses</i></p> <p>Limited to a maximum reimbursement of \$100 every 12 months.</p> <p>Note: Benefits for these services will be paid as reimbursements. When obtaining these 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 above.</p>	<p>International</p> <p>None</p>	Yes	No

Allowed Amounts for International Benefits

Allowed Amounts for International Benefits are the amount we determine that we will pay for Benefits described in this Rider. Allowed Amounts are calculated in accordance with our reimbursement policy guidelines.

When Covered Health Care Services are received from a provider outside the *United States*, Allowed Amounts are calculated, based on the following:

- Any applicable contracted or negotiated fee(s) with that provider.
- If the fees are not contracted or negotiated with the provider, then the Allowed Amounts will be representative of the average and prevailing charge for the same health care service in the same or similar geographic communities where the Covered Health Care Service is provided.

- In all circumstances, the charges shall not exceed the fees that the provider would charge any other party for the same health care service.

Exclusions and Limitations for International Benefits

Exclusions and limitations stated in the Certificate under Section 2: Exclusions and Limitations apply to International Benefits described in this Rider except as modified below.

International Benefits are provided only to the extent that provision of insurance is permitted under the applicable *United States* economic or trade sanctions, and claims submitted under the Policy could be delayed or denied if the required license or other authorization cannot be obtained from the *United States* government.

The following exception to the exclusion for Alternative Treatments applies to International Benefits:

Alternative Treatments

Please note that the exclusions for *Alternative Treatments* in the *Certificate* do not apply to any service, therapy or treatment provided outside the *United States* that is determined to be a Covered Health Care Service as described under *Culturally-Based Services* above.

The following exclusions for Services Provided under another Plan apply to International Benefits:

Services Provided under another Plan

1. Health care services provided while you are covered under a separate policy issued through your Group as stipulated by a foreign governmental requirement.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

The following exclusion for Travel applies to International Benefits:

Travel

1. Health care services provided in a foreign country, except for those services specifically described as Covered Health Care Services in this Rider.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be reimbursed. This exclusion does not apply to *Emergency Evacuation, Medical Repatriation, Repatriation of Remains* and *Emergency Family Reunion* for which Benefits are described above.

All Other Exclusions

1. Health care services provided in countries where U.S. law or local law prohibits us from making payments.
2. Health care services when claims payment and/or coverage is prohibited by applicable law.

Transportation

1. Extra nights in a hospital when you are no longer receiving active treatment which requires you to be hospitalized, for example, when you are awaiting your return flight.

2. Transfers which in our reasonable opinion are inappropriate, based on established clinical and medical practice. We are entitled to conduct a review of your case, when it is reasonable for us to do so. Evacuation or repatriation will not be authorized against the advice of our clinical medical team.
3. Evacuation or repatriation in cases where the local situations, including geography, makes it impossible, unreasonably dangerous or impractical to enter an area, for example, from an oil rig or within a war. Such intervention depends upon and is subject to local and/or international resource availability and must remain within the scope of national and international law and regulations. Interventions may depend on the attainment of necessary authorizations issued by the various authorities concerned, which may be outside our reasonable control or influence.

The following provision regarding claims payment applies to International Benefits:

Claims

How Are Claims Paid?

We make all payments, as we determine, in one of the following ways:

- In the currency of the invoices relating to the claim.
- In U.S. dollars.
- In the currency of your choice.

It is your responsibility to pay any charges which are not eligible for payment under the Policy.

How Are Exchange Rates Calculated?

If it is necessary to make a conversion from one currency to another, we will use the mid-market exchange rate in effect on the date of service.

General Legal Provisions

The following provision regarding Defense Base Act (DBA) coverage applies to International Benefits:

Defense Base Act (DBA) Coverage not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by the *Defense Base Act*.

Defined terms stated in the Certificate under Section 9: Defined Terms apply to International Benefits described in this Rider except as modified below.

Defined Terms

Eligible Person - an employee of the Group or other person connected to the Group who is an Expatriate or Key Local National and meets the eligibility requirements shown in both the Group's *Application* and the Policy.

Expatriate - an Eligible Person who is sent on assignment outside his or her own country, as agreed upon between the Group and us. This definition includes a *United States* citizen who is sent on assignment to a *United States* territory.

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 a determination is made regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

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

- We may consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that health condition if:
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
 - You have a health condition that is likely to cause death within one year of the request for treatment.

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

For International Benefits, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.

International Benefits - the description of how Benefits are paid for Covered Health Care Services received outside the *United States* or in *United States* territories. The Rider will tell you if your plan offers International Benefits and how International Benefits apply.

Key Local National - an Eligible Person, not prohibited by local law, that works and resides within their country of citizenship and who the Group has determined is eligible under the Policy as a condition of their employment and/or because they are essential to the management of their work country's operation.

UnitedHealthcare Insurance Company



William J Golden, President

Vision Materials Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for and provides Benefits for Vision Materials.

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 at the end of this Rider.

Covered Health Care Services

The following provision for Vision Materials is added to the Certificate, Section 1: Covered Health Care Services:

Vision Materials

Benefits are provided for the following vision materials:

- Eyeglass lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.
- Eyeglass frames which mean a structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.
- Contact lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include contact lenses necessary, as determined by your vision care provider, for any of the following:
 - Keratoconus.
 - Anisometropia.
 - Irregular corneal/astigmatism.
 - Aphakia.
 - Facial deformity.
 - Corneal deformity.
 - Pathological myopia.
 - Aniridia.
 - Aniseikonia.
 - Post-traumatic disorders.

Benefits include the fitting/evaluation fees and contacts.

Benefits for vision materials are a percentage of the provider's billed charge.

Vision Materials Reimbursement

When you obtain vision material from a 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 below. Reimbursement will be limited to the amounts stated below in the *Schedule of Benefits*.

To file a claim for reimbursement for vision material provided by a vision care provider, you must give us all of the following information:

- Your itemized receipts.
- Your name.
- Your identification number from the ID card.
- Your date of birth.

Schedule of Benefits

The provision below for Vision Materials is added to the Schedule of Benefits:

When Benefit limits apply, the limit refers to any combination of International Benefits as described in the <i>Expatriate Insurance</i> Rider and Benefits provided within the United States as described in this Rider, unless specifically stated otherwise.			
Amounts which you are required to pay as shown in the <i>Schedule of Benefits</i> are based on Allowed Amounts. The <i>Allowed Amounts</i> provision in the <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What is the Co-payment or Co-insurance you pay? This May Include a Co-payment, Co-insurance or both	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does Annual Deductible Apply?
Vision Materials			
For Eyeglass Frames and Eyeglass Lenses and Contact Lenses: Limited to a maximum reimbursement of \$100 every 12 months. Note: Benefits for these services will be paid as reimbursements. When obtaining these 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 above.	Network None	Yes	No
	Out-of-Network None	Yes	No

Exclusions and Limitations

The exclusion for purchase cost and fitting charge for eyeglasses and contact lenses in the Certificate under Section 2: Exclusions and Limitations, Vision and Hearing is deleted.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read 'W. Golden', with a long horizontal flourish extending to the right.

William J Golden, President

Fertility Preservation for Iatrogenic Infertility Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for fertility preservation for iatrogenic infertility.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

1. The following provision is added to the *Certificate, Section 1: Covered Health Care Services*:

Fertility Preservation for Iatrogenic Infertility

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

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

Benefits for medications related to the treatment of fertility preservation are provided as described under or under *Pharmaceutical Products* in this section.

Benefits are not available for embryo transfer.

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

2. The provision below for *Fertility Preservation for Iatrogenic Infertility* is added to the *Schedule of Benefits*.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Fertility Preservation for Iatrogenic Infertility			
Limited to \$20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is	Network 10%	Yes	Yes

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
enrolled for coverage under the Policy.	<p style="text-align: center;">Out-of-Network</p> <p>30%</p>	Yes	Yes

3. Exclusions from coverage listed in the *Certificate* apply also to this Rider. Exclusion #1 regarding health care services and related expenses for infertility treatments in the *Certificate* under *Section 2: Exclusions and Limitations, N. Reproduction* is replaced with the following:

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to cryo-preservation when used for services as described under *Fertility Preservation for Iatrogenic Infertility* in *Section 1: Covered Health Care Services*.

UnitedHealthcare Insurance Company



William J Golden, President

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services. In addition to the Benefits described in this Rider, Covered Persons are eligible for the services described under *Preventive Care Services* in *Section 1: Covered Health Care Services* in the *Certificate of Coverage*, which include behavioral counseling for healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors, screening for abnormal blood glucose and type 2 diabetes mellitus, and screening for obesity and offer or referral for intensive, multicomponent behavioral interventions for Covered Persons with a body mass index (BMI) for 30 kg/m² or higher.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older with a body mass index of 23 or greater who are not pregnant or nursing an infant, who do not have anorexia or bulimia nervosa and/or who do not have any severe chronic or acute illness, unless approved by their primary care Physician. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or at the number shown on your ID card.

UnitedHealthcare Insurance Company



William J Golden, President

Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនជាអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohji' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ: Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-866-633-2446. ¶

¶

ध्यान आपो: જો તમે **ગુજરાતી (Gujarati)** બોલતા છો તો આપને ભાષાકીય મદદરૂપ સેવા ¶
વિના મૂલ્યે પ્રાપ્ય છે. ¶

કૃપા કરી 1-866-633-2446 પર કોલ કરો. ¶

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

¹For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

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 Care 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.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care 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 prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*, group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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 30 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 according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to 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 according to 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.
- 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 call us at the telephone number on your ID card before requesting a formal appeal. If the 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 representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a 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 us immediately.

How Do You 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 for an appeal should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge 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 shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place 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 shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 30 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place 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 related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

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 January 1, 2022:

We² 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 care 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 related 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, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have 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 enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, 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.
- 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 collect, 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 collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed 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. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **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 purposes 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 collect, use, and 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.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and 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 collect, use, and 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 review of certain treatments or the prevention of disease or disability, if the research study meets federal 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 needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and 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 needed (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 needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **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. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors' Information
 9. Prescriptions
 10. Reproductive Health

11. Sexually Transmitted Diseases

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.

Except for uses and disclosures described and limited as stated 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, call the phone number listed on your health plan 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 change 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 get 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 according 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 get a copy of this notice on your health plan website, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

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 your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail 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, to us 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.

²This Medical Information Notice of Privacy Practices 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 New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, 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 Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; 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.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America;

UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc; 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 Mississippi, Inc.; UnitedHealthcare of New England, 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 the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2022

We³ 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

Depending upon the product or service you have with us, we may 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.
- Information from a consumer reporting agency.

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.
- 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 your health plan ID card or call us at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; getthealthinsurance.com Agency, Inc.; Genoa Healthcare, LLC;

Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health LLC, LLC; OrthoNet, LLC; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

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), if applicable, 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 get, 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), if applicable 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 due to 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 get 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 \$156 a day (subject to adjustment based on inflation) 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 get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: NantMedia Holdings, LLC dba California Times Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

NantMedia Holdings, LLC dba California Times
2300 E Imperial Hwy
El Segundo, CA 90245
(619) 293-1147

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 82-4402852

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

NantMedia Holdings, LLC dba California Times
2300 E Imperial Hwy
El Segundo, CA 90245
(619) 293-1147

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
877-294-1429

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

