UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan CKC2

of

Trace Systems Inc.

Group Number: 919780

Effective Date: January 1, 2024

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Amendments, Riders and Notices (As Applicable)

UnitedHealthcare Choice Plus

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185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

Schedule of Benefits

How Do You Access Benefits?

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

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or Facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

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.

In accordance with state law, we provide direct access without a need for a referral to cancer pain management specialists or oncologists who are authorized to provide cancer pain management services under the Policy and whom the Covered Person has selected.

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

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

Covered Health Care Services provided at Network Facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, Network "Facilities" are limited those defined in the *Certificate*.

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

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

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

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

Does Prior Authorization Apply?

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

When prior authorization is the responsibility of a Network provider, any reduction or denial of Benefits will not affect you. You are also required to obtain prior authorization for Covered Health Care Services received from a Designated Provider as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category.

When you are required to obtain prior authorization in advance from us for Covered Health Care Services, we will have personnel available to provide such authorization whenever needed.

In addition, certain Pharmaceutical Products may be subject to prior authorization due to the following:

- They contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Pharmaceutical Product;
- They contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Pharmaceutical Product;
- There are Therapeutically Equivalent alternatives available; or
- They have an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Pharmaceutical Product.

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

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

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

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

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a 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 Designated Network Benefits, 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 year before you are eligible to receive Benefits. 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. 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. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits*	***Designated Network and Network*** $750 per Covered Person, not to exceed $1,500 for all Covered Persons in a family. ***Out-of-Network*** $2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.

Payment Term And Description	Amounts
table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
The amount stated as a set dollar amount that you must pay for certain Covered Health Care Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Care Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Allowed Amount or the Recognized Amount when applicable.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Care Service category.
Out-of-Pocket Limit	
The maximum you pay or anyone pays on your behalf per year for the Annual Deductible, the Per Occurrence Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Amendment*. The Out-of-Pocket Limit for Designated Network and Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Amendment*. 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. 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. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still	***Designated Network and Network*** $3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible. ***Out-of-Network*** $6,000 per Covered Person, not to exceed $12,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible.

Payment Term And Description	Amounts
will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Co-payments or Co-insurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit.	
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 10%	Yes	Yes
	Air Ambulance 10%	Yes	Yes
	Water Ambulance 10%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground, water or Air Ambulance, as we determine appropriate based on medical necessity. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Air Ambulance 10% *Water Ambulance* 10% ***Out-of-Network*** *Ground Ambulance* 30% ***Out-of-Network*** *Ground Ambulance* *Air Ambulance* Same as Network *Water Ambulance* 30%	 Yes Yes Yes Same as Network Yes	 Yes Yes Yes Same as Network Yes
2. Cellular and Gene Therapy			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, Cellular or Gene Therapy services must be received from a Provider that we have designated as a center of excellence.	***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***		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, 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 as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient Facility charges for the CHD surgery. Depending upon	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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 *Schedule of Benefits*.	***Out-of-Network*** 30%	Yes	Yes
5. Dental Services - Accident Only			
	Network 10% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes 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 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 for diabetes self-management and		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Diabetes Self-Management Items	training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Amendment*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Amendment*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
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. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	***Out-of-Network*** 30%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Includes diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans. **Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-	***Network*** $200 per visit.	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Out-of-Network*** Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under *Preimplantation Genetic Testing (PGT) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
the entire period of time he or she is enrolled for coverage under the Policy.	***Out-of-Network*** 30%	Yes	Yes
11. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.** **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Amendment*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Amendment.		
12. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. 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.			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy.* Note: Benefits for Early Intervention	*Outpatient* $20 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Services and services for the treatment of Autism Spectrum Disorder are not subject to the above annual limits. Visit limits do not apply to Outpatient Habilitative Services for mental health conditions and substance use disorders.			
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 30%	Yes	Yes
13. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear, up to $1,500 per hearing aid every 24 months. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
14. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis. In accordance with Virginia law and as described in the *Certificate of Coverage*, Benefits are provided for a home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to the above annual limits. Visit limits do not apply to *Home Health Care* Services for Mental Health and Substance Use diagnoses. 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 Network provider.	***Network*** 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
15. Hospice Care			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice Facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice Facility.			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
16. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. 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.			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year. For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.	***Designated Network*** None ***Network*** 50% ***Out-of-Network*** 30%	 Yes Yes Yes	 No Yes Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 50% ***Out-of-Network*** 30%	 Yes Yes	 No Yes
18. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Designated Network		
	$150 per service	Yes	No
	Network		
For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.	50%	Yes	Yes, after the Per Occurrence Deductible of $500 per service is satisfied
	Out-of-Network		
	30%	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment Facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).* If you do not obtain prior authorization as required, the amount you are required to pay will be			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
increased to 50% of the Allowed Amount.			
When outpatient visits are subject to payment of a Co-payment, the Co-payment will not exceed 50% of Allowed Amounts.	***Network***		
	Inpatient		
	10%	Yes	Yes
	Outpatient		
	$20 per visit	Yes	No
	10% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
	Out-of-Network		
	Inpatient		
	30%	Yes	Yes
	Outpatient		
	30%	Yes	Yes
	30% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
20. Ostomy and Urologic Supplies			
	Network		
	10%	Yes	Yes
	Out-of-Network		
	30%	Yes	Yes
21. Pharmaceutical Products - Outpatient			
Certain coupons from pharmaceutical	***Network***		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable Co-payment and/or Co-insurance.	10% ***Out-of-Network*** 30%	Yes Yes	Yes Yes
22. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in Network Facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** 10% ***Out-of-Network*** 30%	Yes Yes	Yes Yes
23. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a	***Network*** $20 per visit for a Primary Care	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Physician's office: • Major diagnostic and nuclear medicine described under Major *Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	Physician office visit or $20 per visit for a Specialist office visit ***Out-of-Network*** 30%	 Yes	 Yes
24. Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
In accordance with Virginia law, Benefits are provided for certain	***Network***		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
home visits for mothers following obstetrical care in a Hospital, as prescribed by a Physician.	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. ***Out-of-Network*** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
25. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Amendment*.	***Network*** 10% ***Out-of-Network*** 30%	Yes Yes	Yes Yes
26. Preventive Care Services			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Physician office services	***Network***		
	None	No	No
	Out-of-Network		
	30%	Yes	Yes
Lab, X-ray or other preventive tests	***Network***		
	None	No	No
	Out-of-Network		
	30%	Yes	Yes
Breast pumps	***Network***		
	None	No	No
	Out-of-Network		
	30%	Yes	Yes
27. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Out-of-Network*** 30%	Yes	Yes
28. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. 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.			
	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*.		
29. Rehabilitation Services - Outpatient Therapy			
• 20 visits of physical therapy. • 20 visits of occupational therapy.	***Network*** $20 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• 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. Note: Benefits for Early Intervention Services and services for the treatment of Autism Spectrum Disorder are not subject to the above annual limits. Visit limits do not apply to Outpatient Rehabilitative Services for mental health conditions and substance use disorders.	***Out-of-Network*** 30%	Yes	Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
31. Skilled Nursing Facility/Inpatient Rehabilitation			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. 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.			
Limited to 60 days per year.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
32. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
33. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**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 five business days before TMJ services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.			
	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*.		
34. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
35. Transplantation Services			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, transplantation services must be received from a Designated Provider that we have designated as a center of excellence. We do not require that cornea transplants be received from a Designated Provider center of excellence in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
36. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under	***Network*** $50 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Pharmaceutical Products - Outpatient. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	***Out-of-Network*** 30%	Yes	Yes
37. Urinary Catheters			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
38. Virtual Care Services			
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.	***Network*** *Urgent Care* None ***Out-of-Network***	Yes	No

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

Additional Benefits Required By Virginia Law

39. Chiropractic/Osteopathic Manipulation Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to 30 visits per year. Applies separately for rehabilitative and habilitative services for spinal manipulations and other manual medical interventions. Physical therapy is covered under the *Rehabilitation Services - Outpatient Therapy* Benefit category in this Schedule of Benefits.	***Network*** $20 per visit	Yes	No
	Out-of-Network 30%	Yes	Yes
40. Cleft Lip and Cleft Palate Treatment			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits. For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	10% ***Out-of-Network*** 30%	Yes Yes	Yes Yes
41. Congenital Defects and Birth Abnormalities			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
42. Dental Anesthesia and Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
43. Early Intervention Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment or Co-insurance.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	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.*		
44. Hemophilia and Congenital Bleeding Disorders			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for home treatment of hemophilia or other congenital bleeding disorders that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limits stated under *Durable Medical Equipment (DME),Orthotics and Supplies*	Depending upon where the Covered Health Care Service is provided, Benefits for blood infusion equipment and blood products will be the same as those stated under *Durable Medical Equipment (DME),Orthotics and Supplies, Pharmaceutical Products - Outpatient,* or in the *Outpatient Prescription Drug Rider.*		
45. Vision Correction After Surgery or Accident			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.
    - For Covered Health Care Services that are ***Surgical and Ancillary Services received at Network Facilities on a non-Emergency basis from out-of-Network Physicians****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Designated Network or Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.
    - For Covered Health Care Services that are ***non-Surgical and non-Ancillary Services received at Network Facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
    - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Designated Network or Network Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
    - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

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

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment, or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

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

- **For non-Emergency Covered Health Care Services received at Network Facilities from out-of-Network Physicians** when such services are Surgical and Ancillary Services, or non-Surgical and non-Ancillary Services described in this section, the Allowed Amount is based on either:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*
- For the purpose of this provision, Network "Facilities" are limited to those defined in the *Certificate*.

IMPORTANT NOTICE: For Surgical and Ancillary Services, and for non-Surgical and non-Ancillary Services described in this section, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate.*
- **For Emergency ground ambulance transportation provided by an out-of-Network provider**, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  IMPORTANT NOTICE: Out-of-Network providers may 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 an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates, or subcontractors.

- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third -party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

  IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includesnon-Surgical and non-Ancillary Servicesdescribed in this section.

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider

and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. See *Continuity of Care* provision below. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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

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

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network Facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses. Reimbursement for applicable travel expenses may include reasonable and necessary travel when you get prior approval and need to travel more than 50 miles from your permanent home to reach the Facility where the complex Covered Health Care Services will be performed. Travel costs typically include transportation to and from the Facility, and lodging for the patient and one companion when determined necessary. Call us for complete information regarding travel reimbursement based on your complex Covered Health Care Service.

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

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

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

Continuity of Care

If you are under the care of a Network provider for one of the medical conditions below, and the Network provider caring for you is terminated from the Network for reasons other than cause, 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. The terminated provider will be reimbursed in accordance with our agreement with the provider existing immediately before the provider's termination of participation. Co-payments, Co-insurance, deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

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

- An active course of treatment begun before the provider terminated: Treatment by the terminated provider may continue for 90 days.
- A Pregnancy that has reached the second or third trimester: Treatment by the terminated provider may continue until the postpartum services related to the delivery are completed.

A specified course of treatment for a terminal illness or a related condition: Continuity of care may last for the remainder of the Covered Person's life or until coverage under the Policy terminates.

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

Certificate of Coverage

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

State Corporation Commission

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

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

(804) 371-9944 (fax number)

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

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

E-mail: bureauofinsurance@scc.virginia.gov

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

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

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*.
- Amendments.
- Riders, including the *Outpatient Prescription Drug Rider*.

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 provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

Other Information You Should Have

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

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 the Commonwealth of Virginia. The Policy is subject to the laws of the Commonwealth of Virginia and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Virginia law governs the Policy.

Language contained in this notice regarding your potential rights under ERISA may be required under regulations issued by the *Employee Benefits Security Division (EBSA)* of the *U.S. Department of Labor*. This language is not subject to approval or disapproval by the state insurance department in which the contract is issued for delivery. If you have questions regarding these notices, check your phone directory for the telephone number of the nearest *EBSA* office.

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

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?

Some 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.

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

Office of the Managed Care Ombudsman

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

Phone number: (877) 310-6560

Fax number: (804) 371-9944

Ombudsman@scc.virginia.gov

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. 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 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, directly to the out-of-Network provider, any difference between the amount the provider bills you and any amount that exceeds the Allowed Amount. Amounts which you are required to pay, as shown in the Schedule of Benefits, are based on Allowed Amounts. The Allowed Amounts provision near the end of the Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Out-of-Network Providers may not balance bill a Covered Person for Emergency Services provided to the Covered Person or non-Emergency Services provided to the Covered Person at a Network facility by an out-of-Network provider.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

Following evaluation and validation of 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, except for Emergency Services provided to a Covered Person or non-Emergency Services provided to a Covered Person at a Network Facility by an out-of-Network provider, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. 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 which will be a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. 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.

Standing Referrals

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

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

In addition, if, as determined by your Primary Care Physician, you have an ongoing special medical condition that would most appropriately be coordinated by a Specialist Physician, you may, after our consultation with the Primary Care Physician, receive a referral to a Network Specialist Physician for such condition. Within the treatment period authorized by the referral, such Specialist Physician will be permitted to treat you for the special medical condition without a further referral from your Primary Care Physician and may authorize such referrals, procedures, tests, and other medical services related to the special medical condition as your Primary Care Physician would otherwise be permitted to provide or authorize under the Policy.

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

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

If you have an ongoing special medical condition that requires ongoing care from a specialist, you may receive a standing referral to a Network Specialist Physician for the treatment of the special medical condition. If we, or your Primary Care Physician in consultation with us and the Specialist Physician,

determine that such a standing referral is appropriate, we will make such a referral to the Specialist Physician. The Specialist Physician may be required to provide written notification to your Primary Care Physician of any visit to such Specialist Physician, including a description of the health care services rendered at the time of the visit.

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

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

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

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

1. Ambulance Services

Medically Necessary Emergency ambulance transportation by a licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation to the nearest Hospital where the required Emergency Health Care Services can be performed.

For ground ambulance, you are taken:

- From your home, the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an out-of-Network Hospital to a Network Hospital;

- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

For water or Air Ambulance, you are taken:

- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when we require you to move from an out-of-Network Hospital to a Network Hospital;
- Between a Hospital and an approved Facility.

Benefits include air emergency transportation by fixed wing or rotary wing when ground or water transportation is not appropriate.

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

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care Facility to the closest Network long-term acute care Facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute Facility where the required Covered Health Care Services can be delivered.

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

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

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

Ambulance services are available 24 hours a day, 7 days a week. Network and out-of-Network Emergency and ambulance services are covered.

2. Cellular and Gene Therapy

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

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

3. Clinical Trials

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

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)

- *Centers for Disease Control and Prevention (CDC)*.
- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the *Office of Protection from Research Risks of the NCI.*
- 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 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.

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.

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

5. Dental Services - Accident Only

Dental services in an office or ambulatory setting when all of the following are true:

- Treatment is needed because of accidental damage regardless of date of injury in accordance with the timeframes below.
- For Injuries occurring on or after the effective date of coverage, you must seek care within 12 months of the date the Injury was sustained or as soon after that as possible to be a Covered Health Care Service under the Policy or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

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

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

Benefits for treatment of accidental Injury are limited to Medically Necessary treatment.

Coverage includes Medically Necessary dental work resulting from accidental injury, excluding an injury resulting from chewing or biting. Repair of dental appliances damaged in accidental injury to jaw, mouth or face. Dental appliances needed to treat an accidental injury to the teeth. Dental services, including x-rays, extractions, and anesthesia to prepare the mouth for medical treatments, such as radiation therapy to treat cancer and prepare for transplants are covered.

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.

Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of the diabetic self-management items listed below. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes including treatment of corns, calluses and care of toenails.

Diabetic Self-Management Items and Supplies

Insulin pumps, medical supplies and equipment, and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. Benefits for insulin, blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the Outpatient Prescription Drug Rider.

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

Benefits are provided for DME and 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, crutches, walkers or traction equipment.
- Cochlear implants.
- A standard Hospital-type bed.
- A ventilator, oxygen, oxygen concentrator, and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Nebulizers.
- Dialysis equipment and supplies for use in the home setting for both hemodialysis and peritoneal dialysis.
- Molded head halters.
- Molded, therapeutic shoes for diabetics with peripheral vascular disease.
- Negative pressure wound therapy pumps (wound vacuums).
- Therapeutic shoes for diabetics.
- 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).
- Equipment and supplies used for treatment of lymphedema.
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

Orthotics (including the initial purchase, fitting, adjustment and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part)

Orthotic braces, splints other than foot orthotics, boots and leg braces including needed changes to shoes to fit braces, and attached or built-up shoes attached to a leg brace. Braces that are used for the purpose of supporting a weak or deformed body part (including braces to treat curvature of the spine) and braces restricting or eliminating motion in a diseased or injured part of the body are Covered Health Care Services. Benefits also include arm braces, back braces and neck braces.

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

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

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

Benefits include rental of multi-use and non-disposable equipment that has no other use than medical, and is ordered by a health care provider for use outside a medical Facility. Also included are maintenance

and supplies needed for use of the equipment, such as a battery for a powered wheelchair, as well as necessary repairs except if damage is due to neglect.

8. Emergency Health Care Services - Outpatient

Services and supplies that are required to stabilize or begin treatment in an Emergency whether received from a Network or an out-of-Network provider. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Visits to out-of-Network Emergency rooms for Emergency services and supplies are covered at Network levels and Network cost shares apply. Facility and providers may not balance bill for amounts in excess of the maximum Allowed Amount (as defined in the *Schedule of Benefits*).

In accordance with Virginia and federal law, Covered Health Care Services include services from a Hospital Emergency Facility and provider, less any applicable deductibles, Co-payments or Co-insurance, for medical screening and stabilization services rendered to meet the requirements of the *Federal Emergency Medical Treatment and Active Labor Act*, and if such services are provided by out-of-Network providers, any cost-sharing will not exceed the cost-sharing requirement that would apply if such services were provided on a Network basis.

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). Coverage also includes diagnostic x-ray, laboratory services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and stabilize a patient with an Emergency medical condition.

"Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a Facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

Benefits are not subject to prior authorization and will be provided without regard to of the final diagnosis rendered to a Covered Person.

9. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the critical source of nutrition, for certain conditions which require specialized nutrients or formulas. Coverage also includes any medical equipment, supplies, and services that are required to administer the covered formula and enteral nutrition products. Examples of conditions include but are not limited to:

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

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

For the purpose of this Benefit, "enteral formulas" include but are not limited to:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.

- Modified nutrient content formulas.
- Special food products or supplements

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

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

Benefits for enteral formulas for the treatment of inborn errors or amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status are provided under the Outpatient Prescription Drug Rider.

10. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

11. Gender Dysphoria

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

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

12. Habilitative Services

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

Habilitative services are limited to:

- Physical therapy including services to relieve pain; teach, keep, improve or restore function, and prevent disability after Sickness, Injury, or loss of limb; hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, including treatment of lymphedema. Benefits include services in a Hospital, Freestanding Facility, Skilled Nursing Facility, or an outpatient day rehabilitation program.
- Occupational therapy, which means treatment to teach, keep, improve or restore a physically disabled Covered Person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy, which means treatment for the correction of a speech impairment which results from disease, surgery, Injury, Congenital Anomaly or prior medical treatment or services necessary to improve or teach speech. Speech therapy includes services necessary to teach speech and therapy to treat or develop communication or swallowing skills to correct a speech impairment. Therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age. Speech therapy includes services to identify, assess, and treat speech, language, and swallowing disorders in children and adults.
- Covered services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, medical devices, and services of a social worker or psychologist.
- Post-cochlear implant aural therapy.

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

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

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

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

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress we may request additional medical records.

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.*

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

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

13. 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 through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

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

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.

14. Home Health Care

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

- Ordered by a Physician.

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

Benefits include:

- Diagnostic services.
- Medical/social services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Medical supplies.
- Durable medical equipment.
- Drugs delivered and administered by a health care provider.
- Total Parenteral Nutrition (TPN), enteral nutrition therapy.
- Antibiotic therapy.
- Pain care.
- Drug infusion therapy.
- Blood products.
- Chemotherapy.
- Remote patient monitoring services.
- Physical, speech and occupational therapy.

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

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

Please note that physical, speech, and occupational therapy services provided as part of home care are not subject to separate visit limits for therapy services as described under *Rehabilitation Services - Outpatient Therapy* in the *Schedule of Benefits.*

The home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. The home health care limit does not apply to home infusion therapy or home dialysis.

15. Hospice Care

Hospice care that is recommended by a Physician. "Hospice care" means a coordinated program of home and inpatient care provided directly by or under the direction of a licensed hospice agency. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual, nutritional counseling and respite care for the terminally ill person utilizing a medically directed interdisciplinary team.
- 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.

The services and supplies listed below are Covered Health Care Services when provided by a licensed hospice agency for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, and focusing on the special needs of the patient as one experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life, or meant to cure a terminal illness. Covered services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the Covered Person in order to provide the Covered Person's primary caregiver a temporary break from caregiving responsibilities.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of the Covered Person's condition, including oxygen and related respiratory therapy supplies.

For purposes of this provision, "respiratory therapy" means the introduction into the lungs of dry or moist gases, non-pressurized inhalation; Intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; Chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; Broncho pulmonary drainage and breathing exercises.

- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Covered Person's death. Bereavement services are available to surviving members of the immediate family for one year after the Covered Person's death. Immediate family means your spouse or Domestic Partner, children, stepchildren, parents, brothers and sisters.

Your Physician and hospice medical director must certify that you are terminally ill and likely have less than six months to live. Your physician must agree to care by the hospice and must be consulted in the development of the care plan. The hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Health Care Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Covered Person in hospice. These additional Covered Health Care Services will be covered under other parts of *Section 1: Covered Health Care Services.*

16. Hospital - Inpatient Stay

Services and supplies provided for Injury, Sickness or Pregnancy during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay including anesthesia, drugs and injectable drugs, oxygen, blood and blood products, and hypodermic needles, surgical dressings, splints and syringes.
- General anesthesia and hospitalization services for children under the age of 5, Covered Persons who are severely disabled, and Covered Persons who have a medical condition that requires admission to a Hospital. These services are only provided when it is determined by a licensed dentist, in consultation with the Covered Person's treating Physician that such services are required to effectively and safely provide dental care.
- General nursing services.
- Invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Treatment of fractures and dislocation.
- Therapy services as described under *Therapeutic Treatments - Outpatient* including respiratory therapy. For purposes of this provision, "respiratory therapy" means the introduction into the lungs of dry or moist gases, non-pressurized inhalation; Intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; Chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; Broncho pulmonary drainage and breathing exercises.
- Anesthesia and surgical support when Medically Necessary.
- Medically Necessary pre-operative and post-operative care.
- Room and board in a Semi-private Room (a room with two or more beds) including bed, meals, and special diets in a semi-private room. (Benefits are available for a private room only when Medically Necessary.)
- 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*.)
- A minimum Inpatient Stay of at least 23 hours for a laparoscopy-assisted vaginal hysterectomy and at least 48 hours for a vaginal hysterectomy.
- A minimum Inpatient Stay of at least 48 hours following a radical or modified radical mastectomy and at least 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.
- Newborn infant hearing screenings and all necessary audiological examinations provided in accordance with the guidelines of the *Virginia Hearing Impairment Identification and Monitoring System*, using any technology approved by the *U.S. Food and Drug Administration*, and as recommended by the *National Joint Committee on Infant Hearing*.
- Interhospital transfer for newborn or mother without prior authorization.
- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.

Benefits include inpatient infusion services and nuclear medicine services, when Medically Necessary. Infusion services include infusion of therapeutic agents, medication and nutrients, infusion of enteral nutrition into the gastrointestinal tract, and infusion of prescription medication.

17. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography including low-dose mammograms at age intervals. Benefits include a baseline mammogram for women 35 to 39 years of age, one such mammogram biennially to Covered Persons age 40 through 49, one such mammogram annually to Covered Persons age 50 and over.
- Prostate-Specific Antigen testing (PSA) and digital exams. Benefits include an annual diagnostic examination for the detection of prostate cancer and a prostate-specific antigen test for each Covered Person who is at least 50 years old and asymptomatic, or who is at least 40 years old with a family history of prostate cancer or another prostate cancer risk factor. Coverage for the diagnostic examination will be provided in accordance with guidelines established by the *American Cancer Society*. Services for prostate-specific antigen testing will be covered at least once in any 12-month period.
- Ultrasounds.
- Pathology services.
- EEG and EKG services.
- Echocardiograms.
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).
- Sleep testing. Benefits for any resulting Medically Necessary sleep treatment are available and will be provided based on where the Covered Care Health Service is received (e.g., *Physician's office Services - Sickness and Injury,* Durable Medical Equipment (DME),Orthotics and Supplies) as stated under each applicable category in this section *(Section 1).*

Benefits include:

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

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

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

18. Major Diagnostic and Imaging - Outpatient

Services for PET/CT fusion scans, CT scans, PET scans, MRI, MRA, MRS, CTA, SPECT scan, QCT densitometry, diagnostic CT colonography, nuclear cardiology, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

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

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

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

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

Benefits include the following levels of care:

- Inpatient treatment (including Physician charges).
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following on an inpatient or outpatient basis:

- Diagnostic evaluations, assessment and treatment, and/or procedures including psychological testing.
- Family therapy, including counseling with covered family members to assist with the patient's diagnosis.
- Electroconvulsive therapy (ECT).
- Detoxification, and rehabilitation treatment including Hospital and inpatient professional charges in any Hospital or Facility required by state law.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Services at a Residential Treatment Facility including 24-hour a day nursing care.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care. Services received from a psychiatrist, psychologist, neuropsychologist, LCSW, clinical nurse specialist, *Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC)* or any agency licensed by the state to provide these services are covered.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

Applied Behavioral Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Please refer to the definition of Residential Treatment and Partial Hospitalization in *Section 9: Defined Terms* of this *Certificate* for more detail.

20. Ostomy and Urologic Supplies

Benefits for ostomy supplies and for urologic 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 including injectable drugs and blood products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home. Injections administered at an authorized pharmacy are covered under your *Outpatient Prescription Drug Rider.*

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

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

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product. However, Benefits are available if a non-Designated Dispensing Entity or its intermediary agree to accept reimbursement from Us or our Designee at the same rate as a Designated Dispensing Entity.

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 programs in which you may receive an enhanced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. Please reference the following URL link to view the prescription drug formulary list: www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/non-exchange-commercial-fully-insured-pdls?vanity=statedruglists.

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

Benefits include professional services for test interpretation, x-ray reading, lab interpretation and scan reading.

23. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office or for doctor visits in the home including second surgical opinions and services from a nurse practitioner or Physician's assistant or a Specialist for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a retail health clinic (walk-in) or located in a Hospital. Retail health clinics provide routine care for common illnesses.

Covered Health Care Services include medical education services, including nutrition counseling, 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 treatment.
- Allergy serum.
- Physician's office visits for allergy injections and testing.
- Injectable drugs and drugs administered in an outpatient setting by a Physician.
- Drug infusion therapy.
- Chemotherapy.
- Dialysis.
- Online visits by webcam, chat or voice.
- BRCA testing, fetal screenings and pregnancy testing.

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

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits for PET/CT fusion scans, CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

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

In-person consultation is not required between a Physician and a Covered Person, for services to be appropriately provided through Telehealth/Telemedicine.

24. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services including delivery room and care, routine nursery care during the mother's normal Hospital stay, inpatient room and board, anesthesia and other required medical and Physician services, for prenatal care, postnatal care, delivery and any related complications of Pregnancy for which hospitalization is Medically Necessary. Benefits are provided for Covered Health Care Services for delivery in a home setting provided by a certified nurse midwife. In addition, Benefits also include initial examination of a newborn, maternity care and maternity-related check-ups on an outpatient basis or when hospitalization is Medically Necessary. Benefits for breastfeeding/lactation counseling and equipment, such as breast pumps are covered.

Coverage is provided for both the subscriber and covered dependents.

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 and Dependents in the immediate family. Covered Health Care Services include related tests and treatment.

We will reimburse up to $50 for childbirth education classes. Upon completion of the class, you must submit a copy of the certificate of completion with dates attended, as well as a copy of the canceled check or receipt.

The following screenings for pregnant women are also covered:

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

Benefits also include folic acid supplements and expanded tobacco intervention and counseling for pregnant users.

The following fetal screenings are also covered:

- Genetic and/or chromosomal status of a fetus.
- Anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies as recommended for Grades A and B of the *U.S. Preventive Services Task Force.*

The following covered post-natal screenings include:

- Hemoglobinopathies.
- PKU.

- Hypothyroidism.
- Gonorrhea prophylactic medication.
- Behavioral assessments and measurements.
- Screenings for blood pressure and hearing.

Benefits also include circumcision of a newborn covered male Dependent.

Benefits are available under *Cleft Lip and Cleft Palate Treatment* for dental services and dental appliances for a newborn.

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

- 48 hours for the mother and newborn child from the moment of birth following a normal vaginal delivery.
- 96 hours for the mother and newborn child from the moment of birth 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.

Please note that Benefits include Covered Health Care Services for delivery provided by a certified nurse midwife, including delivery in a home setting. If carrier has no midwives in the Network, an actuarial equivalent such as delivery at a birthing center is required.

Please note that Benefits for pregnancy testing typically fall under *Physician's Office Services - Sickness and Injury* in this section.

Note: Virginia law provides for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital.

25. Preimplantation Genetic Testing (PGT) and Related Services

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

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

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

26. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and

effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* including adult routine physical exams. Benefits also include screening for obesity, abdominal aortic aneurysm, alcohol misuse, colorectal cancer (including annual fecal occult blood test; flexible sigmoidoscopy; colonoscopy or in appropriate circumstances, radiologic imaging), cervical cancer, high blood pressure, Type 2 Diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, screenings for BRCA risk assessment and genetic testing if appropriate after genetic counseling, osteoporosis, syphilis, chlamydia, gonorrhea, and tobacco use. Benefits also include counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention, PSA test and breast cancer chemoprevention, digital exams and aspirin use to prevent cardiovascular disease (which is covered under the *Outpatient Prescription Drug Rider*).
    - Adult, adolescent and children immunizations, including immunizations administered to a newborn Enrolled Dependent child from birth to thirty-six months of age, that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.* Physician assistants, nurse practitioners, registered nurses or licensed practical nurses, or pharmacists are health professionals who may administer vaccinations to children and may also provide to the person who refers the child for immunizations a certificate stating that such immunizations have been administered.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings including hearing screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include assessments for hepatitis B, alcohol and drug use, behavioral, oral health risk; medical history; BMI measurements; screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, lead, obesity, sexually transmitted infection (STI), HIV, tuberculin, and vision. Also included are counseling for obesity and STI. Benefits also include prescription fluoride chemoprevention supplements for children up to 16 years of age (which is covered under the *Outpatient Prescription Drug Rider*).
    - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include well woman visits, domestic and interpersonal violence screenings, breast cancer mammography screenings, domestic and interpersonal violence counseling, and STI screenings. These services include, but may not be limited to:
    - Screening for gestational diabetes: Coverage is provided for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - Human papillomavirus testing: Coverage is provided for high-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
    - Counseling for sexually transmitted infections: Annual counseling on sexually transmitted infections for all sexually active women.
    - Counseling and screening for human immune deficiency virus: Annual counseling and screening for human immune-deficiency virus infection for all sexually active women.
    - Counseling for breast cancer genetic testing (BRCA).
    - Screenings for cervical cancer.
    - Breast cancer chemoprevention.

- Contraceptive methods and counseling: Coverage includes all *U.S. Food and Drug Administration (FDA)* approved contraceptive methods, including drugs, injectable, patches, rings, diaphragms, IUDs, implants, and sterilization procedures, including patient education and counseling for all women. Reversals of elective sterilizations are not covered. FDA-approved contraceptive drugs, and contraceptive devices and products available over-the-counter, are covered under the *Outpatient Prescription Drug Rider*. Coverage for a prescription for a 12-month supply of hormonal contraceptives is available when dispensed or furnished at one time is available under the *Outpatient Prescription Drug Rider.*
- Breastfeeding support, supplies and counseling.

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

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

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

- Tobacco use screening, smoking cessation products and counseling by the *United States Preventive Services Task Force*. For tobacco cessation medications. nicotine patches and gum when obtained with a prescription, please refer to the *Outpatient Prescription Drug Rider.*

You may obtain additional information regarding Benefits for preventive care at the website: http://www.healthcare.gov/center/regulations/prevention.html or by calling the telephone number on your ID card.

27. Prosthetic Devices

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

- Artificial arms, legs, feet and hands including any portion of an artificial arm, leg, foot or hand.
- Artificial face, eyes, ears and nose.
- Artificial limbs and components Medically Necessary for daily living.
- 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.*
- One wig per Benefit period needed following cancer treatment.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Composite facial prosthesis.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Benefits are not available for prosthetic devices designed primarily for an athletic purpose. 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.

Medically necessary prosthetic device" includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

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

Benefits are available for adjustments, fittings, the components of the prosthetic device, repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances and Prosthetics.*

28. Reconstructive Procedures

Reconstructive procedures, on an inpatient or outpatient basis, when the primary purpose of the procedure is either of the following:

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery. The primary result of the procedure is not a changed or improved physical appearance.

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

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

29. Rehabilitation Services - Outpatient Therapy

Benefits include outpatient services in a Hospital, Free Standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program. Covered services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, medical devices, and services of a social worker or psychologist. Short-term outpatient rehabilitation services are limited to:

- Physical therapy including services to relieve pain; teach, keep, improve or restore function; and prevent disability after illness, Injury, or loss of limb, hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, including treatment of lymphedema.
- Occupational therapy which means treatment to teach, keep, improve or restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy which means treatment for the correction of a speech impairment which results from disease, surgery, Injury, Congenital Anomaly or prior medical treatment or services necessary

to improve or teach speech. Services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment.

- Pulmonary rehabilitation therapy including outpatient short-term respiratory care following an illness or Injury.
- Cardiac rehabilitation therapy which means the process of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease. Benefits include medical evaluation, training, supervised exercise, and psychosocial support following a cardiac event. Services will not be provided for home programs (other than home health care services), ongoing conditioning, and maintenance care.
- Post-cochlear implant aural therapy.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

30. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

- The Facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- General anesthesia and hospitalization services for dental care for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to an outpatient basis at a Hospital or Alternate Facility or a Physician's office. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.

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

31. 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 including Medically Necessary drugs and biological drugs/products.
- Skilled nursing and related services for convalescent and rehabilitative care.
- Room and board in a Semi-private Room (a room with two or more beds). Benefits are available for a private room only when Medically Necessary.

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

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

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

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

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

32. Surgery - Outpatient

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

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

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

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

Benefits include:

- The Facility charge and the charge for supplies and equipment including blood and blood products, hypodermic needles, surgical dressing, splints, syringes, and anesthesia.
- General anesthesia and hospitalization services for children under the age of 5, Covered Persons who are severely disabled, and Covered Persons who have a medical condition that requires admission on an outpatient basis at a Hospital or Alternate Facility or a Physician's office. These services are only provided when it is determined by a licensed dentist, in consultation with the Covered Person's treating Physician that such services are required to effectively and safely provide dental care.

- Invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Treatment of fractures and dislocation.
- Anesthesia and surgical support when Medically Necessary.
- Medically Necessary pre-operative and post-operative care.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Male and female sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered.
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.

33. Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and craniomandibular disorders and/or associated muscles when deemed Medically Necessary to attain functional capacity of the affected part.

Diagnostic procedures: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, arthrocentesis and trigger-point injections.

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

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants. Including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.

Benefits include treatment involving any bone or joint of the head, neck, face or jaw.

34. Therapeutic Treatments - Outpatient

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

- Dialysis services for acute renal failure and chronic (end-stage) renal disease (both hemodialysis and home intermittent peritoneal dialysis, home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis; dialysis treatments in an outpatient dialysis facility or doctor's office). Benefits are also provided for home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Benefits also include home dialysis and training for you and the person who will help you with home self-dialysis.
- Intravenous or by-injection chemotherapy (chemical or biological antineoplastic agents) or other intravenous drug infusion therapy, nursing, Durable Medical Equipment and drug services that are delivered and administered to you through an I.V (including in the home). Coverage also includes injectables that are not self-administered.

- Respiratory therapy which means the introduction into the lungs of dry or moist gases, non-pressurized inhalation; Intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- Chemotherapy which means treatment of an illness by chemical or biological antineoplastic agents.
- Radiation oncology/administration and complex decongestive therapy in connection with lymphedema. Outpatient self-management training and education for the treatment of lymphedema.
- Radiation therapy includes, but is not limited to, treatment by x-ray, radium or radioactive isotopes, cobalt or high energy particle sources and includes the rental or cost of radioactive materials. Also includes materials and supplies, administration, treatment planning, and other covered services.
- Proton radiation therapy shall not be held to a higher standard of clinical evidence than other types of radiation therapy for cancer treatment.
- Infusion services include infusion of therapeutic agents, medication and nutrients, infusion of enteral nutrition into the gastrointestinal tract, infusion of blood and blood products and infusion of prescription medication.
- Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy.

Covered Health Care Services include medical education services including training and education in connection with lymphedema treatment 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:

- Outpatient self-management training and education for the treatment of lymphedema.
- The Facility charge and the charge for related supplies and equipment including those related to treatment of lymphedema.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

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

35. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Autologous bone marrow transplants for breast cancer.

- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient Benefits described under *Section 1: Covered Health Care Services*.

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

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

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

When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive Benefits.

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 50 miles from your permanent home to reach the Facility where the covered transplant procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. For lodging and ground transportation Benefits, we will cover costs up to the current limits set forth in the *Internal Revenue Code.*

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

Coverage for complications from the donor procedure for up to six weeks from the date of procurement.

36. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center includes treatment at an Urgent Care Center for urgent but non-emergent care. An urgent health problem is an unexpected illness or Injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life

threatening and do not call for the use of an Emergency room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

37. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

38. Virtual Care Services

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

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

Benefits are available for the following:

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

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

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical Facilities (*CMS* defined originating Facilities).

Additional Benefits Required By Virginia Law

39. Chiropractic/Osteopathic Manipulation Services

Chiropractic services provided by or under the direction and supervision of a licensed chiropractor. Benefits include therapy to treat problems of the bones, joints, and back, spinal manipulations and other manual medical interventions covered under the chiropractor's scope of practice as well as services for people with disabilities in an inpatient or outpatient setting. In addition, manipulation services by an osteopath are also covered. Benefits are available for habilitative and rehabilitative services. For

purposes of this Benefit, "habilitative services" means services that help you keep or improve skills and functioning of daily living.

Chiropractic and Osteopathic Manipulation therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Note: For rehabilitative chiropractic/osteopathic manipulation services and devices only, Benefits do not include spinal or other manual medical interventions for an illness or Injury other than musculoskeletal. Services must involve goals you can reach in a reasonable period of time. Benefits will end when progress toward the goal ends. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed treatment or if treatment goals have previously been met. Benefits under this section are not available for preventive chiropractic treatment.

40. Cleft Lip and Cleft Palate Treatment

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

41. Congenital Defects and Birth Abnormalities

Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities on the same basis as any other Covered Health Care Service.

42. Dental Anesthesia and Facility Services

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

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

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

43. Early Intervention Services

Early Intervention Services for Enrolled Dependent children from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under *Part H* of the *Individuals with Disabilities Education Act (20 U.S.C. s1471 et seq.)*.

For purposes of this benefit Early Intervention Services are defined in *Section 9: Defined Terms*.

44. Hemophilia and Congenital Bleeding Disorders

Blood and the administration of blood products and blood infusion equipment required on an outpatient basis or for the home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the outpatient program or home treatment program is under the supervision of a state-approved hemophilia treatment center.

For purposes of this Benefit, the following defined terms apply:

- "Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

- "Blood infusion equipment" includes, but is not limited to, syringes and needles.
- "Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate.
- "State-approved hemophilia treatment center" means a hospital or clinic that receives federal or state *Maternal and Child Health Bureau* and/or *Centers for Disease Control* funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

45. Vision Correction After Surgery or Accident

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

Benefits are limited to the purchase and fitting of eyeglasses or contact lenses when prescribed to replace the human lens lost due to surgery or Injury.

Benefits are limited to the purchase and fitting of eyeglasses when"pinhole" eyeglasses are prescribed for use after surgery for a detached retina.

Benefits are limited to the purchase and fitting of contact lenses when contact lenses are prescribed in place of surgery in the following situations:

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

Benefits include:

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

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

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 an Amendment to the Policy.

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or other similar programs except for individual or group therapy provided in these settings by a licensed mental health or substance use disorder provider.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia) except as specifically described under *Dental*

Anesthesia and Facility Services in *Section 1: Covered Health Care Services* and *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 acute traumatic Injury, cancer, cleft lip, or ectodermal dysplasia or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics). This exclusion does not apply to cleft lip/palate or ectodermal dysplasia-related dental services for which Benefits are provided as described under *Cleft Lip and Cleft Palate Treatment* in *Section 1: Covered Health Care Services.*
5. Treatment of natural teeth due to accidental injury occurring on or after your effective date under the Policy when treatment was not sought within 12 months after the Injury and approval was not received from us.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
3. Oral appliances for snoring.
4. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Appliances for temporomandibular joint syndrome (TMJ) pain dysfunction except for appliances described under Temporomandibular Joint Services in *Section 1: Covered Health Care Services*.

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

6. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. Benefits for such products are described in the *Outpatient Prescription Drug Rider*.

2. Self-administered or self-infused medications. Benefits for such products are described in the *Outpatient Prescription Drug Rider*. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to State-approved hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.

4. Over-the-counter drugs and treatments. Please refer to the *Outpatient Prescription Drug Rider* for a description of Benefits for Preventive Care Medications, which include select over-the-counter medications including tobacco cessation medications, as required by *USPTF*.

5. Growth hormone therapy.

6. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

7. Pharmaceutical Products that have not been prescribed by a Specialist.

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

E. Experimental or Investigational or Unproven Services

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

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

This exclusion does not apply to any prescribed drug that has not been approved by the *U.S. Food and Drug Administration (FDA)* for the treatment of the specific condition for which the drug has been prescribed, provided that both of the following criteria are met:

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

This exclusion does not apply to any drug approved by the *FDA* for use in the treatment of cancer pain even if the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed for a patient with intractable cancer pain.

F. Foot Care

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

This exclusion does not apply to preventive foot care if such foot care is Medically Necessary.

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

    This exclusion does not apply to:

    - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
    - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
    - Ostomy supplies for which Benefits are provided as described under *Ostomy and Urologic Supplies* in *Section 1: Covered Health Care Services.*
    - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Ostomy and Urologic Supplies* in *Section 1: Covered Health Care Services*.
    - Blood infusion equipment for which Benefits are provided as described under *Home Treatment of Hemophilia and Congenital Blood Disorders* 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. Nutrition

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

I. Personal Care, Comfort or Convenience

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

J. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins unless Medically Necessary.
    - Sclerotherapy treatment of veins.
    - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.

This exclusion does not apply to:

- Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
- Surgery or procedures to correct congenital abnormalities that cause functional impairment.
- Surgery or procedures on newborn children to correct congenital abnormalities.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Surgical treatment of gynecomastia for cosmetic purposes.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.

5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

K. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Routine rehabilitation and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Group speech therapy.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
8. 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.
9. Biofeedback.
10. 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.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment or if the treatment is otherwise required because of a medical condition or Injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part.
12. Surgical and non-surgical treatment of morbid obesity.
13. Smoking cessations programs not affiliated with us.
14. 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*.
15. Helicobacter pylori *(H. pylori)* serologic testing.
16. Intracellular micronutrient testing.
17. Cellular and Gene Therapy services not received from a Designated Provider.

L. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse or Domestic Partners, 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.

M. 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 services required to diagnose, treat or correct underlying causes of infertility. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     - Assisted reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
     - Preimplantation Genetic Testing (PGT) and related services.
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

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

3. Costs of donor eggs and donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

5. The reversal of voluntary sterilization except for services to reverse a non-elective sterilization that resulted from an illness or Injury.

6. Elective fertility preservation.

7. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

N. Services Provided under another Plan

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

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or

Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and Facilities are reasonably available to you.

3. Health care services during active military duty.

O. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health care services for transplants involving animal organs.

P. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.

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

Q. Types of Care

1. Custodial Care or maintenance care.

2. Domiciliary care.

3. Private Duty Nursing.

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

5. Rest cures.

6. Services of personal care aides.

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

R. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to Benefits for glasses or contact lenses as described under *Vision Correction After Surgery or Accident* in *Section 1: Covered Health Care Services*.

2. Routine vision exams, including refractive exams to determine the need for vision correction.

3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).

4. Eye exercise or vision therapy.

5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

6. Bone anchored hearing aids except when either of the following applies:

- You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

S. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

12. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital Facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

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

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

Special Enrollment Period

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

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

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

If we end this coverage because of a decision to no longer issue this particular type of health benefit plan, we will provide written notice to the Group and all Subscribers at least 90 days prior to the renewal date of the Policy. If we end this coverage because of a decision to no longer issue any type of health benefit plan, we will provide written notice to the Virginia *State Corporation Commission*, the Group, and all Subscribers at least 180 days prior to the renewal date of the Policy.

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. We will provide you written notice of when the coverage ends.

  If the Policy is ended due to non-payment of Premium on the part of the Group, we will provide the Group written or printed notice of when coverage ends, including a specific date by which coverage will end if overdue Premium is not paid. Your coverage will end 15 days after such notice has been mailed.

- **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 will provide you written notice of when coverage ends.

- **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. We will provide you written notice of when coverage ends.

- **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. We will provide you written notice of when coverage ends.

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.

We will provide a 31-day notice of when coverage ends, except for non-payment of Premiums and change in eligibility status.

Fraud or Intentional Misrepresentation of a Material Fact - Rescission of Coverage

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

We will provide at least 30 days prior written notice of when coverage ends in the case of rescission of coverage including:

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

You have a right to a refund of all Premiums less any claims paid beyond the date on which coverage ends.

You are responsible for paying us for the cost of previously received services based on the Allowed Amount, when applicable, for such services, less any Co-payments made or Premium paid for such services.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage. Coverage will remain in full force and effect for a reasonable period of time. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- 180 days from the date coverage would have ended when the entire Policy was terminated.
- A succeeding carrier elects to provide replacement coverage to the Covered Person without limitation as to the disabling condition.

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.

Notification Requirements and Election Period

The Group will provide you with written notification of the right to continuation coverage within 14 days of when coverage ends under the Policy. You must elect continuation coverage within 31 days of receiving this notification but no more than 60 days after termination of eligibility under the Policy. You should get an election form from the Group or employer.

Continuation Coverage under State Law

Continuation coverage under state law is available to you only if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your

coverage ends under the Policy as described below. Continuation coverage under state law is available to Groups that are not subject to the terms of COBRA. You should call your Group's plan administrator if you have questions about your right to continue coverage under state law.

Coverage under the Policy is continued for a period of 12 months immediately following the date of the termination of your eligibility, without evidence of insurability, subject to the following requirements:

- The coverage ceases because of loss of eligibility under the Policy, prior to becoming eligible for Medicare or Medicaid benefits. You are not eligible for this continuation of coverage if you are insurable under a replacement group coverage or health care plan without waiting periods or preexisting conditions;
- Your eligibility for coverage under the group policy ceased because the Covered Person was discharged from employment by the group policyholder for gross misconduct. As used in this subdivision, "gross misconduct" means any conduct connected with the individual's work that would constitute misconduct under § 60.2-618, including deliberately and willfully engaging in conduct evincing a complete disregard for the employer's workplace standards and policies.
- The application for the extended coverage is made to the Group within 31 days of notice from the Group but no more than 60 days after termination of eligibility under the Policy; and
- The premium for continuing the group coverage shall be at the current rate applicable to the Policy and shall be paid monthly.

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

- 12 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The policyholder or contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
- The date coverage is or could be obtained under any other group health plan.

The date the Policy ends

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?

Other than Covered Health Care Services from an out-of-Network provider as the result of an Emergency or for non-Emergency Services provided to a Covered Person at a Network Facility by an out-of-Network provider, when you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Under Virginia law, written notice of a claim shall be given to us 20 days after the occurrence or commencement of any loss covered by the Policy. You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date the 90-day period expires, Benefits for that health care service will be denied or reduced, as determined by us. Failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

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

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

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

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

We will furnish forms for filing proof of loss to you. If the forms are not furnished within 15 days after we have received notice of any claim under the Policy, as described immediately above, you shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time frame noted above, written proof covering the occurrence, character, and extent of the loss for which a claim is made.

Payment of Benefits

Benefits under the Policy will be paid within 60 days after receipt of proof of loss and all required information.

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider without our consent. We will not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a subscriber. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

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

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

In the event of a Covered Person's death, any portion of any Benefits provided for Covered Health Care Services may be paid to the health care services provider in our discretion.

In accordance with Virginia law the following statement must be included in the *Certificate*:

- Benefits for loss of life of the person insured, if applicable, shall be payable to the beneficiary designated by the person insured.

Additional information about how we process payment of Benefits under the Policy, and the form in which Benefits are paid, is available in the Group Policy, which is hereby incorporated by reference into this *Certificate*.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care. Concurrent review requests are considered pre-service requests. "Concurrent review" means utilization review conducted during your stay or course of treatment in:

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

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

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 first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request 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. We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.
- 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 from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request 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 30 days from receipt of a request for review of the first level appeal decision.

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

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

Concurrent Review Requests

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

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

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

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

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

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations, you may request that we handle your appeal on an urgent basis, even if you have already requested a standard appeal (outlined in the section above, "Pre-service Requests for Benefits and Post-service Claim Appeals"). When this occurs:

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

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

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

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

Exhaustion of Internal Appeal Process

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

- You have completed the standard internal appeals process as described above under *Pre-service Requests for Benefits and Post-service Claim Appeals*.
- You did not receive a decision from us within the required time frame concerning a standard internal appeal.
- You have requested an urgent internal appeal as described under *Urgent Appeals that Require Immediate Action*, in which case you may also make a written or verbal request for an expedited external review (see *Expedited External Review* below).
- We waived the requirement to exhaust the internal appeal process.
- We violated Virginia internal appeal requirements, except where such violation is a "de minimus" violation, which means the violation does not cause, and is not likely to cause, prejudice or harm to you so long as we demonstrate that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange between you and us. You may:
  - Request written explanation of the violation from us, and we will provide written explanation within 10 days of receipt of your request.
  - Request *IRO* review to determine if we have violated Virginia internal appeal requirements. The *IRO* will provide a written response to you, us and the commission within 10 days of receipt of your request. If rejected, within 5 days we must notify you of your right to resubmit and pursue an internal appeal.

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

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

Office of the Managed Care Ombudsman

P.O. Box 1157

Richmond, VA 23218

Phone number: (877) 310-6560

Fax number: (804) 371-9944

E-mail: Ombudsman@scc.virginia.gov

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

Office of Licensure and Certification

Virginia Department of Health

9960 Mayland Drive, Suite 401

Richmond, Virginia 23233-1463

Telephone: (800) 955-1819 or (804) 367-2106

Fax: (804) 527-4503

E-mail: mchip@vdh.virginia.gov

Virginia External Review Program

If, after exhausting your internal appeals, as described above under *Exhaustion of Internal Appeal Process*, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing (within 15 days of our receipt of the second-level pre-service appeal or within 30 days of our receipt of the second-level post-service appeal), you may be entitled to request an external review of our determination. This process is administered by the *Virginia Bureau of Insurance*. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

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

If you wish to appeal our final decision as described above, you or your representative may file a request for a standard external review in writing with the *Virginia Bureau of Insurance*. If, in urgent situations as detailed below, you wish to file a request for an expedited external review, you or your representative may do so by sending a written request to the *Virginia Bureau of Insurance's* address. We will provide to you, at the time a final adverse decision is reached, a copy of the *Virginia Bureau of Insurance's* external review request form, which contains the address and information for requesting an external review.

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

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

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

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

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

Bureau of Insurance - External Review

P.O. Box 1157

Richmond, VA 23218

(877) 310-6560

E-mail: externalreview@scc.virginia.gov

Standard External Review

A standard external review is comprised of all of the following:

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

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

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

After we complete the preliminary review, we will issue a notification in writing to you, your representative, if applicable, and the *Virginia Bureau of Insurance*. If the request is eligible for external review, the *Virginia Bureau of Insurance* will assign an *IRO* to conduct such review. A Covered Person is not required to have exhausted his or her health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

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

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

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

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

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

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

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process. A Covered Person is not required to have exhausted his or her health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

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

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

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

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

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the *Virginia Bureau of Insurance* will assign an *IRO* in the same manner utilized to assign standard external reviews to *IROs*. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim anew and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request except that, for an expedited external review concerning Experimental or Investigational Services or Unproven Services, the *IRO* will provide notice of the final external review decision within 48 hours after the date it receives an opinion from all assigned clinical reviewers, who will have up to five days to provide an opinion to the *IRO*. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you and to us.

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

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

1. Plan includes: group insurance contracts, group health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: liability insurance contracts or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be coordinated 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 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 coordinate the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

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

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

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

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 or Domestic Partner does, that parent's spouse's or Domestic Partner'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 or Domestic Partners.

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable. You will not be responsible for an amount that exceeds the Allowed Amount if Covered Health Care Services are received from a Network provider, if Emergency Covered Health Care Services are received from an out-of-Network provider, if Emergency Air Ambulance services are received from and out-of-Network provider or if Surgical and Ancillary Services are received at a Network Facility from out-of-Network provider on a non-Emergency basis.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

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

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.

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 after it has been in force for two years unless we received the statement signed by the Subscriber.

In addition, no statement made by any person insured under the Policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and
- Unless the statement is contained in a written instrument signed by him.

The above does not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

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

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

Are Incentives Available to You?

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

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

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

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

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

Who Provides Administrative Services?

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

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

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy. For any change that amounts to a Benefit reduction, we will provide the Group with written notice of a benefit reduction sixty (60) days before it becomes effective. The Group will notify you of the change thirty (30) days prior to the effective date of the benefit reduction. Any exercise of such discretion is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

Any provision of 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.

Nothing in this provision will require the disclosure of personal or privileged information about an individual that is protected from disclosure under Virginia insurance laws and regulations, or under any other applicable federal or state law or regulation.

Do We Require Examination of Covered Persons?

During the pendency of the claim, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

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

Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B.

If you 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.

When Do We Receive Refunds of Overpayments?

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

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

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

Whenever payment has been made by UnitedHealthcare Insurance Company in error, we will have the right at any time to recover an overpayment from the person or entity that was overpaid. Any benefit reduction would be from a payment being made to the Covered Person or provider who received the payment in error. We reserve the right to recover overpayments by deducting or offsetting any amounts paid in error from any pending or future claim. The reductions will equal the amount of the required refund. Additional information about our right and methods for recovering overpayments is available in the Group Policy, which is hereby incorporated by reference into this *Certificate*.

Reduction of future Benefits will be from Benefits payable to the person or entity that was overpaid. The reductions will equal the amount of the required refund.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after proof of loss has been filed in accordance with the Policy. After completing that process, if you want to bring a legal action against us you must do so within three years of the date that proof of loss was required to be filed.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application*, individual Subscriber enrollment forms and any Riders and/or Amendments, make up the entire Policy that is issued to the Group. No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to such person's beneficiary or personal representative. All statements made by the Group or Covered Persons shall be deemed representations and not warranties. A copy of any application of the Group shall be attached to the Policy when issued.

Section 9: Defined Terms

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

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

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

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.
- For Emergency Health Care Services provided by an out-of-Network provider or for non-Emergency services provided at a Network facility by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or the commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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

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

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

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

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

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

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

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

Autism Spectrum Disorder -any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or

maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

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

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

The following conditions apply:

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

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

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

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

Designated Diagnostic Provider - a provider and/or Facility that we have identified through our designation programs as a Designated Diagnostic Provider.

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

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

Designated Provider - a Network provider and/or Facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category.

A Designated Provider may or may not be located within your 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 Network provider or Facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent.

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

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

Early Intervention Services - speech and language therapy, occupational therapy, physical therapy, and assistive technology and devices. Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment.

This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary. The Benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention Services Benefit.

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

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

- Serious jeopardy to the mental or physical health of the individual,

- Danger of serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Health Care Services - health care services that are rendered by Network or out-of-Network providers 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). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or Facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

  b) Any other conditions as specified by the Secretary.

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

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
   - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)

3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

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

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

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

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

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

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

Independent Freestanding Emergency Department - a health care Facility that:

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

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

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

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

In accordance with *Generally Accepted Standards of Medical Practice*.

- Clinically appropriate, in terms of type, frequency, extent and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.

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

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

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

Medically Necessary Prosthetic Device - includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

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

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

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or

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

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. 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 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.

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

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

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you 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 that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Treatment shall be provided over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Per Occurrence Deductible - the portion of the Allowed Amount or the Recognized Amount when applicable, (stated as a set dollar amount) that you must pay for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount or the Recognized Amount when applicable.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

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

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

Please Note: Any podiatrist, dentist, psychologist, optician, professional counselor, psychologist, clinical social worker, physical therapist, chiropodist, clinical nurse specialist, audiologist or speech pathologist, certified nurse midwife, marriage and family therapist, athletic trainer when services are rendered in an office setting or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Enrollment Forms.
- 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.
- An act of rape.

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

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

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

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

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

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

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the Facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

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

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at Network Facilities by out-of-Network Physicians, when such services are either Surgical and Ancillary Services, or non-Surgical and non-Ancillary Services. For the purpose of this provision, "Network Facilities" are limited to those defined in *14 VAC 5-405-20* and *§ 38.2-3438 of the Code of Virginia*.

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

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

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

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

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

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

Residential Treatment - treatment in a Facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services including Medically Necessary treatment of eating disorders anorexia nervosa and bulimia nervosa. It must meet all of the following requirements:

- Offers individualized and intensive treatment and includes: observation and assessment by a psychiatrist weekly or more often, rehabilitation, therapy, education, and recreational or social activities.
- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
    - Room and board.
    - 24-hour a day nursing care.
    - 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.

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

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

Service Area - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time. A description of the Service Area is provided to you at the time of enrollment.

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

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

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

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

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

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

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

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

Surgical and Ancillary Services - any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

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

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. technology for the purpose of diagnosing or treating a patient, providing remote patient monitoring services or consulting with other health care providers regarding a patient's diagnosis or treatment. It does not include the use of audio-only telephone, e-mail, facsimile, or online questionnaire. The site may be a *CMS* defined originating Facility or another location such as a Covered Person's home or place of work.

Telemedicine services means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided.

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

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through Facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, and are either:

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

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- **Urgent Care Center** - a Facility that provides urgent and short-term medical care, without an appointment, for urgent care for Covered Health Care Services.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments or Co-insurance or other payments that vary depending on which of the Tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

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

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the Tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product. Refer to *Benefit information* in this *Schedule of Benefits* for exceptions.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the Tier placement of the reference product may change. Therefore, your Co-payment or Co-insurance may change or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

Refill Synchronization

Prescription Drug Products dispensed by a Network Pharmacy for a partial supply of a covered prescription drug, in order to synchronize your medications, will be covered at a prorated cost-sharing rate.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation 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 Amendment are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. However, you or your prescriber may request an override exception and we will provide determination no later than 72 hours after receipt of the request for the step therapy override exception. An expedited exception request will be reviewed with a determination provided no later than 24 hours following the request.

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

What Do You Pay?

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

The amount you pay or that is paid on your behalf for any of the following under this Amendment will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	$5,000 per Covered Person.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's Tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment 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 or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment or Co-insurance may	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment or Co-insurance for Prescription Drug Products on the List of Preventive Medications. You are not responsible for paying a Co-payment or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

Payment Term And Description	Amounts
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 number on your ID card. Your Co-payment or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, 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. **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 or Co-insurance for one or more Prescription Orders or Refills. **Variable Co-payment Program**: To the extent allowed by Federal law, certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment or Co-insurance. **Prescription Drug Products**	

Payment Term And Description	Amounts
Prescribed by a Specialist: You may receive a reduced or increased Co-payment or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** The Tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's Tiering decisions. If the change involves moving a Prescription Drug Product to a higher Tier, we will provide you notice of the change 30 days prior to the effective date of the change. 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.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. 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 or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment or Co-insurance that applies will reflect the number of days dispensed. 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.	Your Co-payment 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. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $150 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $500 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $150 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $500 per Prescription Order or Refill. Note: There are two exceptions which will be made without additional cost-sharing beyond that provided for the Prescription Drug List in the member's covered Benefits: • If the provider determines that the Prescription Drug Product on Tier 1, Tier 2, or Tier 3 of the Prescription Drug List does not provide an appropriate therapy for your medical condition, the provider may substitute

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**
	another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level. • If you have been receiving a Prescription Drug Product for at least six months prior to the development or revision of Tier 1, Tier 2, or Tier 3 of the Prescription Drug List, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level if the provider determines that the Prescription Drug Product in Tier 1, Tier 2, or Tier 3 is an inappropriate or potentially harmful therapy for your medical condition. Requests for Prescription Drug Products due to either of these exceptions will be acted on within one business day of receiving the request. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List. For information about this process, please refer to the *Outpatient Prescription Drug* Rider, *Section 4: Your Right to Request an Exclusion Exception*.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • 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. • You may obtain up to 12 cycles of the same contraceptive at one time if you pay a Co-payment or Co-insurance for each cycle supplied. At least one contraceptive of each of the female-controlled *U.S. Food and Drug Administration* -approved contraceptive methods is covered	Your Co-payment 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. For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $70 per Prescription Order or Refill. Note: There are two exceptions which will be made without

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**
without member cost share. 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 or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. For insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed $50 for an individual prescription of up to a 30-day supply.	additional cost-sharing beyond that provided for the Prescription Drug List in the member's covered Benefits: • If the provider determines that the Prescription Drug Product on Tier 1, Tier 2, or Tier 3 of the Prescription Drug List does not provide an appropriate therapy for your medical condition, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level. • If you have been receiving a Prescription Drug Product for at least six months prior to the development or revision of Tier 1, Tier 2, or Tier 3 of the Prescription Drug List, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level if the provider determines that the Prescription Drug Product in Tier 1, Tier 2, or Tier 3 is an inappropriate or potentially harmful therapy for your medical condition. Requests for Prescription Drug Products due to either of these exceptions will be acted on within one business day of receiving the request. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List. For information about this process, please refer to the *Outpatient Prescription Drug* Rider, *Section 4: Your Right to Request an Exclusion Exception*.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you	Your Co-payment 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. For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-

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**
pay a Co-payment or Co-insurance for each cycle supplied. 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 or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. For insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed $50 for an individual prescription of up to a 30-day supply.	Network Reimbursement Rate after you pay $35 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $70 per Prescription Order or Refill. Note: There are two exceptions which will be made without additional cost-sharing beyond that provided for the Prescription Drug List in the member's covered Benefits: • If the provider determines that the Prescription Drug Product on Tier 1, Tier 2, or Tier 3 of the Prescription Drug List does not provide an appropriate therapy for your medical condition, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level. • If you have been receiving a Prescription Drug Product for at least six months prior to the development or revision of Tier 1, Tier 2, or Tier 3 of the Prescription Drug List, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level if the provider determines that the Prescription Drug Product in Tier 1, Tier 2, or Tier 3 is an inappropriate or potentially harmful therapy for your medical condition. Requests for Prescription Drug Products due to either of these exceptions will be acted on within one business day of receiving the request. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List. For information about this process, please refer to the *Outpatient Prescription Drug* Rider, *Section 4: Your Right to Request an Exclusion Exception*.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a	Your Co-payment or Co-insurance is determined by the PDL Management Committee's Tier placement 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**
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, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills. For insulin drugs the total amount of Deductible, Co-payments or Co-insurance shall not exceed $150 for an individual prescription of up to a 90-day supply.	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. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $25 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $87.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $175 per Prescription Order or Refill. Note: There are two exceptions which will be made without additional cost-sharing beyond that provided for the Prescription Drug List in the member's covered Benefits: • If the provider determines that the Prescription Drug Product on Tier 1, Tier 2, or Tier 3 of the Prescription Drug List does not provide an appropriate therapy for your medical condition, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level. • If you have been receiving a Prescription Drug Product for at least six months prior to the development or revision of Tier 1, Tier 2, or Tier 3 of the Prescription Drug List, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, or Tier 3 Co-payment or Co-insurance level if the provider determines that the Prescription Drug Product in Tier 1, Tier 2, or Tier 3Tier 1, Tier 2, Tier 3, or Tier 4 is an inappropriate or potentially harmful therapy for your medical condition. Requests for Prescription Drug Products due to either of these exceptions will be acted on within one business day

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**
	of receiving the request. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List. For information about this process, please refer to the *Outpatient Prescription Drug* Rider, *Section 4: Your Right to Request an Exclusion Exception*.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

This Rider to the Certificate 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. Some 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

Jessica Paik, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes Tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into Tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple Tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may, from time to time, change the placement of a Prescription Drug Product among the Tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Group, except if the change amounts to a Benefit reduction, we will provide the Group with written notice of a Benefit reduction sixty (60) days before it becomes effective. The Group will notify you of the change thirty (30) days prior to the effective date of the Benefit reduction.

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. Please reference the following URL link to view the prescription drug formulary list: www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/non-exchange-commercial-fully-insured-pdls?vanity=statedruglists.

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 650629

Dallas, TX 75265-0629

Designated Pharmacies

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

If you 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, unless, a non-Designated Pharmacy has notified us or our intermediary that it agrees to accept reimbursement at the rate applicable to a Designated Pharmacy as payment in full.

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

Smart Fill Program - Split Fill

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

Services of Out-of-Network Pharmacies or Its Intermediary

Notwithstanding any provision in this Rider to the contrary, you have coverage for outpatient prescription drug services provided to you by an out-of-Network pharmacy that has previously notified us of its agreement to accept reimbursement for its services at rates applicable to Network pharmacies including any applicable Co-payment, Co-insurance or deductible (if any) amounts as payment in full to the same extent as coverage for outpatient prescription drug services provided to you by a Network provider. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating Network Pharmacy agreement with us within thirty days of being requested to do so in writing by us, unless and until the pharmacy executes and delivers the agreement.

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

We may receive rebates for drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. We will pass these rebates on to you. When rebates

are passed on to you, they are applied and taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

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

Variable Co-payment Program

Certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Specialty Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

Special Programs

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

Maintenance Medication Program

If you require some 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.

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

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

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

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

However, Benefits for any Prescription Drug Product approved by the *Federal Drug Administration (FDA)* for use in the treatment of cancer pain are covered even if the supply limit is exceeded if the prescription in excess of the supply limit has been prescribed for a patient with intractable cancer pain.

Benefits are provided for Medical Formulas for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status.

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.

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

Pharmacy which fails to timely execute and deliver such agreement will continue to be treated as a non-Designated Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

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.

This *Outpatient Prescription Drug Rider* offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. This exclusion does not apply to Medicaid.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera, a 12-month supply of hormonal contraceptives when dispensed or furnished at one time and other injectable drugs used for contraception.
10. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic or convenience purposes.
14. Prescription Drug Products that we determine do not meet the definition of a Covered Health Care Service. For information about requesting an exclusion exception, please refer to *Section 4: Your Right to Request an Exclusion Exception*.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.

17. Certain Prescription Drug Products for tobacco cessation.

18. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available Tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process which is explained in detail in Section 4 of this document or you may call the telephone number on your ID card.

    Note: There are two exceptions, which will be made without additional cost-sharing beyond that provided for the Prescription Drug List in the member's covered Benefits:

    - If the provider determines that the Prescription Drug Product on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List does not provide an appropriate therapy for your medical condition, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, Tier 3 or Tier 4 Co-payment or Co-insurance level.
    - If you have been receiving a Prescription Drug Product for at least six months prior to the development or revision of Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List, the provider may substitute another Prescription Drug Product which will be covered at the Tier 1, Tier 2, Tier 3 or Tier 4 Co-payment or Co-insurance level if the provider determines that the Prescription Drug Product in Tier 1, Tier 2, Tier 3 or Tier 4 is an inappropriate or potentially harmful therapy for your medical condition.

    Requests for Prescription Drug Products due to either of these exceptions will be acted on within one business day of receiving the request. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available Tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, please refer to *Section 4: Your Right to Request an Exclusion Exception.*

19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)

20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.

21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to Medical Formulas for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy

allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status.

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Some Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. Dental products, including but not limited to prescription fluoride topicals. This does not include prescription fluoride supplements for children up to 16 years of age.

29. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product unless Medically Necessary.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products, including associated services.

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

32. Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

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

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a Network 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.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Medical Formulas - special medical formulas which are the primary source of nutrition for the Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status by partial or exclusive feeding by means of oral intake or enteral feeding by tube.

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.

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 or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services T ask Force including tobacco cessation products including nicotine patches and gum when obtained with a prescription. Benefits also include aspirin used to prevent cardiovascular disease*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include fluoride supplements for children up to 16 years of age.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits include oral contraceptives, patches and self-injectable 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.

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 medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.
- Self-administered injectable drugs.
- Flu shots and their administration.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with some illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Tier(s) - the different levels of cost sharing to which a Prescription Drug Product may be assigned by the Prescription Drug List (PDL) Management Committee.

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.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the *Certificate* provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older who have a BMI of 23 or greater and who desire to lose weight. 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.

The following are Covered Health Care Services:

- 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.

You are not eligible for this program when:

- Younger than 13
- Older than 72
- Pregnant
- Nursing an infant
- Anorexia or Bulimia Nervosa (present or recent history)
- Severe liver, heart, kidney, neurologic, psychiatric or any severe chronic or acute illness

If you have any questions about this program, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

UnitedHealthcare Rewards Rider

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards wellness program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse or Domestic Partner.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health Reimbursement Account (HRA)* or *Health Savings Account (HSA)* or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 steps per day	You can earn rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Health-Related Actions and/or Activities	One or more actions and/or activities defined by us and aimed at the following: • Health education; • Improving health; or • Maintaining health	

You may access your actions and/or activity tracking and rewards on the mobile application or www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to a or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.

UnitedHealthcare Insurance Company

Jessica Paik, President

Virtual Behavioral Health Therapy and Coaching Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

Starting January 1, 2021, Virginia state law may protect you from "balance billing" when you get:

- ***EMERGENCY SERVICES*** from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital; or
- ***NON-EMERGENCY SURGICAL OR ANCILLARY SERVICES*** from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center or other health care facility.

What is balance billing?

- An **"IN-NETWORK"** health care provider has signed a contract with your health insurance plan. Providers who haven't signed a contract with your health plan are called **"OUT-OF-NETWORK"** providers.
- In-network providers have agreed to accept the amounts paid by your health plan after you, the patient, has paid for all required cost sharing (copayments, coinsurance and deductibles for covered services).
- But, if you get all or part of your care from out-of-network providers, you could be billed for the difference between what your plan pays to the provider and the amount the provider bills you. This is called "balance billing."
- The new Virginia law prevents certain balance billing, ***but it does not apply to all health plans.***

Applies	May Apply	Does Not Apply
• Fully insured managed care plans, including those bought through HealthCare.gov • The state employee health plan • Group health plans that opt-in	• Employer-based coverage • Health plans issued to an employer outside Virginia • Short-term limited duration plans	• Health plans issued to an association outside Virginia • Health plans that do not use a network of providers • Limited benefit plans

How can I find out if I am protected?

Be sure to check your plan documents or contact your health plan to find out if you are protected by this law. When you schedule a medical service, ask your health care provider if they are in-network. Insurers are required to tell you (on their websites or on request) which providers are in their networks. Hospitals and other health care providers also must tell you (on their websites or on request) which insurance plans they contract with as in-network providers. Whenever possible, you should use in-network providers for your health care to avoid paying more.

After you receive medical services, your health plan will send you an "Explanation of Benefits" (EOB) that will tell you what you must pay the provider. **Save the EOB** and check that any bills you receive are not more than the amount listed.

When you *cannot* be balance billed:

If the new law applies to your health plan, an out-of-network provider can no longer balance bill or collect more than your plan's in-network cost-sharing amounts for either (1) emergency care or (2) when you

receive lab or professional services (like surgery, anesthesiology, pathology, radiology, and hospitalist services) at an in-network facility.

What should I know about these situations?

Your cost-sharing amount will be based on what your plan usually pays an in-network provider in your area. These payments must count toward your in-network deductible and out-of-pocket limit. If the out-of-network provider collects more than this from you, the provider must refund the excess with interest.

Exception: If you have a high deductible health plan **with** a Health Savings Account (HSA) or a catastrophic health plan, you must pay any additional amounts your plan is required to pay to the provider, up to the amount of your deductible.

What if I am billed too much?

If you are billed an amount more than your payment responsibility shown on your EOB, or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's (SCC) Bureau of Insurance.

To contact the SCC for questions about this notice visit: scc.virginia.gov or call: 1-877-310-6560.

Language Assistance Services

We[1] 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 الأتصال 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: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ 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 yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 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.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] 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

[1]For 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 your 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, 2024:

We[2] 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 (when permitted by applicable law) 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 in accordance with applicable state and federal law. 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

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **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.

[2]This 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.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; 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. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of 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 Freedom Insurance Company; 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, 2024

We[3] 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.

[3]For 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: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, 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; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC 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, and if you have exhausted the claims procedures available to you under the plan, 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: Trace Systems Inc. Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Trace Systems Inc.

1934 Old Gallows Rd Suite 600

Vienna, VA 22124

(703) 962-9747

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): 22-3687941

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:

Trace Systems Inc.

1934 Old Gallows Rd Suite 600

Vienna, VA 22124

(703) 962-9747

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.