

UnitedHealthcare Select Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan AKLV

of

County of Los Angeles

Enrolling Group Number: 716822

Effective Date: January 1, 2019

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Schedule of Benefits

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are restricted to Covered Health Services provided by Network providers for the following: acupuncture services; infertility services; obesity surgery; rehabilitation services - outpatient therapy and Manipulative Treatment; vision examinations and wigs.

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

DIRECTORY OF NETWORK PROVIDERS

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

AVAILABILITY OF TELEPHONE TRIAGE OR SCREENING SERVICES

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

In addition to accessing *Customer Care*, you are able to access a registered nurse at Optum's Nurseline, 24 hours per day, 7 days per week by contacting the myNurseline phone number on the back of your ID card or by visiting www.myuhc.com. Once logged into the www.myuhc.com portal, the *Ask a Nurse* option will be available, and you may chat online or use the phone number provided to you to speak to a nurse. Optum's Nurseline can help you:

- Chat with a nurse live on www.myuhc.com.

- Understand treatment options.
- Ask medication questions.
- Choose appropriate medical care.
- Locate available local resources.
- Find a Physician, Hospital or specialist.

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

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

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

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357) if you reside in the State of California

213-897-8921 if you reside outside of the State of California

You may write the California Department of Insurance at:

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

ACCESS TO A NETWORK PROVIDER:

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

Timely Access To Care

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

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

In-person appointment wait times:

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

Telephone wait times:

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

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

Important Language Information:

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

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

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

Language services are at no cost to you. Written information may be available in some languages. If you need more help, call 1-800-927-HELP (1-800-927-4357).

ANNUAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Covered Persons will have to meet a higher Annual Deductible and Out-of-Pocket Maximum when a non-Network provider is chosen to provide Covered Health Services.

Accessing Benefits

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

Selecting a Network Primary Physician

You may select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Subscriber, in order to obtain Network Benefits. A Network Primary Physician will be able to coordinate all Covered Health Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you may select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Subscriber, for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Physician for an Enrolled Dependent child. You do not need a referral from a Primary Physician and may seek care directly from a Specialist Physician, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Physician by contacting *Customer Care* at the telephone number shown on your ID card.

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

- **Emergency Health Services Provided by a Non-Network Provider** - Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **California Insurance Code §10112.27 requires a health insurer to cover Emergency Health Services in an emergency department of a Hospital without the need for prior authorization, regardless of whether the provider is a Network Provider under the plan, and subject to the same cost sharing required if the services were provided by Network Provider. You will not pay more than the Network cost sharing amount.**
- **Covered Health Services that are NOT Emergency Health Services Provided by a Non-Network Provider that is not chosen by you** - Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, or as a result of receiving services in a contracting facility, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **You will not pay more than the Network cost sharing amount. The Network cost sharing amount means the same cost sharing that you would pay for the same Covered Health Services if they were received from a contracting individual health professional. Additionally the Network deductible and out-of-pocket maximum apply for Covered Health Services rendered by a non-Network provider in a Network contracting health facility, or as a result of receiving services in a contracting facility, including a hospital, ambulatory surgery or other outpatient setting, laboratory and radiology or imaging center. When you receive Covered Health Services from a Network facility and as a result of which, you receive additional Covered Health**

Services from a non-Network individual health professional, you will not pay more than the Network cost sharing amount.

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

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

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

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

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

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

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

Prior Authorization

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

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

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

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact 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 fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-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 a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

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

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Breast pumps.
- Breast cancer services.

- Clinical trials.
- Congenital heart disease surgery.
- Dental anesthesia services.
- Dental services - accidental.
- Diabetes treatment.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Gender Dysphoria - surgical services (genital surgery or mastectomy) when a Network provider makes a written referral, and the services requested are Covered Health Services that meet the requirements described in our Gender Dysphoria (Gender Identity Disorder) guideline. Our guideline is available upon request by calling the telephone number for *Customer Care* on your ID card.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Infertility services.
- Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.
- Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.
- Mastectomy services.
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electroconvulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Behavioral Health Treatment.
- Pain management.
- Prosthetic devices over \$1,000 in cost per device.
- Prosthetic devices incident to a laryngectomy.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.

- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

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

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

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

Care Management

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

Special Note Regarding Medicare

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

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. The Annual Deductible for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual 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.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Network</p> <p>\$300 per Covered Person, not to exceed \$1,500 for all Covered Persons in a family.</p> <p>Non-Network</p> <p>\$1,500 per Covered Person, not to exceed \$3,000 for all Covered Persons in a family.</p>
Out-of-Pocket Maximum	
<p>The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. The Out-of-Pocket Maximum for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Network</p> <p>\$5,000 per Covered Person, not to exceed \$13,700 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p>Non-Network</p> <p>\$15,000 per Covered Person, not to exceed \$45,000 for all Covered Persons in a family. For Non-Network Emergency Health Services, the Out-of-Pocket Maximum is \$5,000 per Covered Person and \$13,700 for all Covered Persons in a family.</p>

Payment Term And Description	Amounts
	The Out-of-Pocket Maximum includes the Annual Deductible.
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
Prior Authorization Requirement			
<p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as reasonably possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Emergency Ambulance	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80%	Yes Yes	Yes Yes
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as determined to be appropriate.	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80%	Yes Yes	Yes Yes
	Non-Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80%	Yes Yes	Yes Yes
2. Clinical Trials			
Prior Authorization Requirement			
<p>You must obtain prior authorization as soon as reasonably possible if participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of</i>	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Benefits.</i></p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however if the non-Network provider does not agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.</p>	<p>each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p>		
3. Congenital Heart Disease Surgeries			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health 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 Service category in this <i>Schedule of Benefits.</i></p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>80%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
4. Dental Services - Accident Only			
<p>Prior Authorization Requirement</p> <p>For Network and Non-Network Benefits you must obtain prior authorization five business days or as soon as reasonable possible before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Network 80% Non-Network Same as Network	Yes Same as Network	Yes Same as Network
5. Diabetes Services			

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .
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6. Diabetes Treatment	
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Prior Authorization Requirement

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

Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician. Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i> .
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.	<p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.</p>		
7. Durable Medical Equipment			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years.</p> <p>To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
8. Emergency Health Services - Outpatient			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i>.</p>	<p>Network 80%</p> <p>Non-Network Same as Network</p>	<p>Yes</p> <p>Same as Network</p>	<p>Yes</p> <p>Same as Network</p>
<p>9. Gender Dysphoria</p>			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as reasonably possible for any of the services listed in the <i>Certificate</i> for Gender Dysphoria treatment arises.</p> <p>In addition, you must contact us 24 hours before admission for an Inpatient Stay.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
10. Hearing Aids			
Limited to \$2,500 in Eligible Expenses every year. Benefits are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
11. Home Health Care			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
12. Hospice Care			
Prior Authorization Requirement			
For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Any combination of outpatient and inpatient Network and Non-Network Benefits are limited to 180 days per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. Limited to 5 respite care visits per Covered Person per year. One visit equals up to 24 hours of respite care	Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
services. Respite care visits not to exceed five consecutive days at a time.	Non-Network 50%	Yes	Yes
13. Hospital - Inpatient Stay			
Prior Authorization Requirement			
For Non-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 (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
14. Infertility Services			
Prior Authorization Requirement			
You must obtain prior authorization as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to \$15,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services</i> below.	Network 80%	Yes	Yes
	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
15. Lab, X-Ray and Diagnostics - Outpatient			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement			
For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days or as soon as reasonably possible before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Lab Testing - Outpatient	Network 80%	Yes	No
	Non-Network 50%	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	Network 80%	Yes	No
	Non-Network 50%	Yes	No
16. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Prior Authorization Requirement			
For Non-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days or as soon as reasonably possible before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	No
	Non-Network 50%	Yes	Yes
17. Mental Health Services			
Prior Authorization Requirement			
For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions.			
In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p>Network</p> <p><i>Inpatient</i></p> <p>80%</p> <p><i>Outpatient</i></p> <p>80%</p> <p>80% for Partial Hospitalization/Intensive Outpatient Treatment</p> <p>Non-Network</p> <p><i>Inpatient</i></p> <p>50%</p> <p><i>Outpatient</i></p> <p>50%</p> <p>50% for Partial Hospitalization/Intensive Outpatient Treatment</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
18. Ostomy Supplies			
	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
19. Pharmaceutical Products - Outpatient			
	<p>Network</p> <p>80%</p>	<p>Yes</p>	<p>Yes</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
20. Physician Fees for Surgical and Medical Services			
Covered Health Services provided by a non-Network facility based Physician in a Network facility, or as a result of receiving services in a contracting facility, will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i> .	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
21. Physician's Office Services			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. 	Network 80%	Yes	No

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<p>Non-Network</p> <p>50%</p>	<p>Yes</p>	<p>Yes</p>
22. Chiropractic Treatment			
<p>Benefits are limited as follows: 12 visits per year combined (Network and Out-of-Network Benefits).</p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
23. Pregnancy - Maternity Services			
<p>We encourage you to notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that you may enrolled in that are designed to achieve the best outcomes for you and your baby.</p> <p>Prior Authorization Requirement</p> <p>You may receive obstetrical and gynecological Covered Health Services directly from a Physician without a referral or seeking prior authorization. For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>We pay for Covered Health Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing</p>	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
program administered by the State Department of Health Services. There is no cost share for this Benefit.	that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy. Non-Network Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
24. Preventive Care Services			
Prior Authorization Requirement			
For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Physician office services	Network 100%	Yes	No
	Non-Network 100%	Yes	No
Lab, X-ray or other preventive tests	Network 100%	Yes	No
	Non-Network 100%	Yes	No
Breast pumps	Network 100%	Yes	No
	Non-Network 100%	Yes	No
25. Prosthetic Devices			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
26. Reconstructive Procedures			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
27. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
<p>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of pervasive developmental disorder or Autism Spectrum Disorders.</p> <p>Any combination of physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy and cognitive rehabilitation therapy is</p>	Network 80%	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
limited to 30 visits per year.	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
28. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
29. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement			
For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days or as soon as reasonably possible before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to: <ul style="list-style-type: none"> 30 days per year in a Skilled Nursing Facility. 30 days per year in an Inpatient Rehabilitation Facility. 	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
30. Substance Use Disorder Services			
Prior Authorization Requirement			
For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?																																																
<p>an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions.</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>																																																			
<table border="1"> <tr> <td colspan="4">Network</td> </tr> <tr> <td colspan="4"><i>Inpatient</i></td> </tr> <tr> <td>80%</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td colspan="4"><i>Outpatient</i></td> </tr> <tr> <td>80%</td> <td>Yes</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>80% for Partial Hospitalization/Intensive Outpatient Treatment</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td colspan="4">Non-Network</td> </tr> <tr> <td colspan="4"><i>Inpatient</i></td> </tr> <tr> <td>50%</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td colspan="4"><i>Outpatient</i></td> </tr> <tr> <td>50%</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> <tr> <td>50% for Partial Hospitalization/Intensive Outpatient Treatment</td> <td>Yes</td> <td>Yes</td> <td>Yes</td> </tr> </table>				Network				<i>Inpatient</i>				80%	Yes	Yes	Yes	<i>Outpatient</i>				80%	Yes	Yes	No	80% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes	Yes	Non-Network				<i>Inpatient</i>				50%	Yes	Yes	Yes	<i>Outpatient</i>				50%	Yes	Yes	Yes	50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes	Yes
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50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes	Yes																																																
31. Surgery - Outpatient																																																			
<p align="center">Prior Authorization Requirement</p> <p>For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>																																																			
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	80%	Yes	Yes
	Non-Network 50%	Yes	Yes
32. Temporomandibular Joint Services			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Covered Health Services are payable in the same manner as surgery for other medical conditions.	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
33. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement			
For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
34. Transplantation Services			
Prior Authorization Requirement			
<p>For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	Network 80% Non-Network 50%	Yes Yes	Yes Yes
35. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i> • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i> • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i> • Outpatient surgery procedures 	Network 80%	Yes	No

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>described under <i>Surgery - Outpatient</i>.</p> <ul style="list-style-type: none"> Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	<p>Non-Network</p> <p>50%</p>	<p>Yes</p>	<p>Yes</p>
36. Virtual Visits			
<p>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>Non-Network Benefits are not available.</p>	<p>Yes</p> <p>Non-Network Benefits are not available.</p>	<p>No</p> <p>Non-Network Benefits are not available.</p>
37. Vision Examinations			
<p>Limited to 1 exam every 2 years.</p>	<p>Network</p> <p>100% after you pay a Copayment of \$10 per visit</p> <p>Non-Network</p> <p>Non-Network Benefits are not available.</p>	<p>Yes</p> <p>Non-Network Benefits are not available.</p>	<p>No</p> <p>Non-Network Benefits are not available.</p>
Additional Benefits Required By California Law			
38. Breast Cancer Services			
<p align="center">Prior Authorization Requirement</p> <p align="center">Depending upon where the Covered Health Service is provided, any applicable authorization</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
39. Dental Anesthesia Services			
Prior Authorization Requirement			
<p>For Non-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 (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>Services are limited to Covered Persons who are one of the following:</p> <ul style="list-style-type: none"> • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age. 	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
40. Mastectomy Services			
Prior Authorization Requirement			
<p>Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this</p>			

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>Schedule of Benefits.</i>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>41. Off-Label Drug Use and Experimental or Investigational Services</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>42. Osteoporosis Services</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>43. Phenylketonuria (PKU) Treatment</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement			
For Non-Network Benefits, you must obtain prior authorization before obtaining formulas or special food products for the management and treatment of Phenylketonuria (PKU). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
44. Prosthetic Devices - Laryngectomy			
Prior Authorization Requirement			
Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
45. Telehealth Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

Eligible Expenses

Benefits for Covered Health Services are based on Eligible Expenses. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount that is an Eligible Expense as described below. For Covered Health Services provided by a Non-Network provider, you will be responsible to the non-Network provider for any amount billed that is greater than the amount that is an Eligible Expense as described below.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are 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 Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- ▶ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

IMPORTANT NOTICE: Non-Network providers at a Network facility may not bill you for any difference between the provider's billed charges and the Eligible Expense described here.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician that is not chosen by you, or as a result of receiving services in a contracting facility, the Eligible Expense is based on the greater of 125% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* or the average contracted rate for the same or similar service within the geographic market.

IMPORTANT NOTICE: Non-Network facility based Physicians at a Network facility that are not chosen by you, or as a result of receiving services in a contracting facility, may not bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

The following provision only applies to Covered Health Services that are not subject to California Insurance Code §10112.8. Please refer to the above provision titled "Covered Health Services Provided by a Non-Network Provider that are NOT Emergency Health Services from a non-Network facility based Physician that you have chosen" for more information.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician that you have chosen, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

50% of *CMS* for the same or similar laboratory service.

45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: When you choose to use Non-Network facility based Physicians, they may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the greater of:

- The median amount negotiated with Network providers for the same service.

- The amount for the Emergency Health Service calculated using the same method used for non-Network Benefits. Please see the provision titled "**For Non-Network Benefits, Eligible Expenses are based on either of the following**" under the *Eligible Expenses* section in the *Schedule of Benefits* for additional information.
- The amount that would be paid under Medicare for the Emergency Health Service, excluding any Network Copayment or Coinsurance.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

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

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

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

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

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a health condition or other medical problem that requires prompt

medical attention and that has a limited duration. Completion of Covered Health Services will be provided for the duration of the acute condition.

- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, health condition, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, as determined by us in consultation with the Covered Person and the terminated Network provider and consistent with good professional practice. Completion of Covered Health Services under this provision will not exceed 12 months from termination date of the provider's agreement.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Services will be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement.
- **The care of a newborn child between birth and age 36 months.** Completion of Covered Health Services will not exceed 12 months from the termination date of the provider's agreement.
- **Performance of a surgery or other procedure.** Performance of a surgery or other procedure that has been recommended and documented by the Network provider to occur within 180 days of the termination date of the provider's agreement.

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

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

Second Medical Opinion

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

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

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment (including, but not limited to, a chronic condition);
- When the clinical indications are not clear, or are complex and confusing;

- When a diagnosis is in doubt due to conflicting test results;
- When the treating Physician is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the initial treating Physician and still have serious concerns about the diagnosis or treatment.

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

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

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

Timely Access to Care

Appointment wait times are as follows:

- *Emergency Health Services are available and accessible within the plan's service area 24 hours, 7 days a week. Ambulance services for the service area served by the plan to transport the Covered Person to the nearest 24-hour facility with Physician coverage*
- Urgent health care services that do not require prior authorization are offered within 48 hours of the request. Urgent health care services that require prior authorization are offered within 96 hours of the request.
- Non-urgent care primary care and non-urgent, non-Physician Mental Health Services are offered within 10 business days of the request.
- Non-urgent specialist care and ancillary services are offered within 15 business days of the request.

Interpreter services will be coordinated with scheduled appointments for Covered Health Services in a manner that ensures the provision of interpreter services at the time of the appointment.

Designated Facilities and Other Providers

If you have a medical condition that needs special services, we may direct you to a Designated Facility and/or a Designated Physician chosen by us. Medical conditions that may require special services include medical conditions that require transplantation services or obesity surgery. Case management would enable the member to be directed to the appropriate facility/physician to maximize care.

If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to

obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses.

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

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

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

Limitations on Selection of Providers

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

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

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

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

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

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

Changes to the Document

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

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

Other Information You Should Have

We have the right to change, modify, withdraw or add Benefits, or to terminate 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 specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

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

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

Introduction to Your Certificate

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

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

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

Don't Hesitate to Contact Us

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

Our administrative function regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received is based on this contract and is subject to the other terms, limitations and exclusions set out in this *Certificate* and *Schedule of Benefits*. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will do the following:

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

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

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

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

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

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

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

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

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

1. Ambulance Services

Emergency:

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

- A reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance services.
- The treating Physician determines that the Covered Person must be transported to another facility because the Emergency medical condition is not stabilized and the care the Covered Person requires is not available at the treating facility.
- For purposes of this Benefit, "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the

absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- placing the Covered Person's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
 - there is inadequate time to effect safe transfer to another Hospital prior to delivery, or
 - a transfer poses a threat to the health and safety of the Covered Person or unborn child.

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

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

Non-Emergency:

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

2. Clinical Trials

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

- Cancer or other Life-Threatening disease or condition.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is:

- Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition, or
- Either:
 - the referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon his/her meeting the conditions that are eligible for the clinical trial, or

- the Covered Person provides medical and scientific information establishing that his/her participation in such trial would be appropriate based upon the individual meeting the conditions that are eligible for the clinical trial.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.

- *Centers for Medicare and Medicaid Services (CMS).*
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
- A 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* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

With respect to a clinical trial for the treatment of cancer, Benefits are available when the Covered Health Services are provided by either Network or non-Network providers. However, if the non-Network provider does not agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the Covered Person enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.

3. Congenital Heart Disease Surgeries

Congenital heart disease (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 and hypoplastic left or right heart syndrome.

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

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

4. Dental Services - Accident Only

Dental services when all of the following are true:

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

within 60 days of the health condition and if extenuating circumstances exist due to the severity of the health condition.)

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

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

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

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

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the health condition by implant, dentures or bridges.

5. Diabetes Services

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

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

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

6. Diabetes Treatment

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

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

7. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

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

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

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

Examples of Durable Medical Equipment include:

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

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

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

Benefits are available for repairs and replacement, except that:

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

8. Emergency Health Services - Outpatient

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

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

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

9. Gender Dysphoria

Benefits for the treatment of Gender Dysphoria include the following services:

- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Male to Female:

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

Female to Male:

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

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets the following criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older. (Note: Where approval or denial of Benefits is based solely on the age of the individual, a case-by-case medical director review is necessary.)
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
 - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated). In consultation with the patient's Physician, this determination is made on a case-by-case basis through the authorization process.

10. Hearing Aids

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

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

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

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

11. Home Health Care

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

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

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

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

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

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.

12. Hospice Care

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

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

13. Hospital - Inpatient Stay

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

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

14. Infertility Services

Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

For purposes of this Benefit, infertility means either:

- the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of infertility, or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.
- In order to be eligible for Benefits, the Covered Person must also have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

15. Lab, X-Ray and Diagnostics - Outpatient

Services health condition-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

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

Benefits under this section include:

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

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

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

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

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

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

Benefits under this section include:

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

17. Mental Health Services

Benefits for Mental Health Services include Covered Health Services for the diagnosis and treatment of Mental Illnesses. Mental Illness is defined as those mental health or psychiatric diagnostic categories that

are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Prescription drugs.

Benefits under this section also include the diagnosis and all Medically Necessary treatment of Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child under the same terms and conditions that apply to medical conditions as required by California insurance law. This includes, but is not limited to, Copayments and deductibles.

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

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

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

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

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

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

18. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

19. Pharmaceutical Products - Outpatient

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

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

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

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

20. Physician Fees for Surgical and Medical Services

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

21. Physician's Office Services

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

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

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

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

22. Chiropractic Treatment

Services provided by a Physician or licensed therapy provider for Chiropractic Treatment.

23. Pregnancy - Maternity Services

Benefits for Pregnancy include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

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

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

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

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

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

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

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

24. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including cancer screening tests and counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions. Tobacco use and tobacco-related disease counseling and interventions include a minimum of eight counseling sessions of at least 10 minutes each. Screening tests for heredity breast and ovarian cancer are covered as a preventive care service when they are an "A" or "B" recommendation of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including FDA approved AIDS vaccine if recommended by the *United States Public Health Services*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*, including screening for blood lead levels, Phenylketonuria (PKU) testing, periodic health evaluations, and laboratory services in connection with periodic health evaluations.

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

- Screening newborns for hearing problems, thyroid disease, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
- For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders.
- Screening and counseling for obesity in children and adolescents, age 6-18 years old. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including comprehensive, intensive behavioral interventions to promote improvement in weight status.

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

- The *Recommendations for Preventive Pediatric Health Care*, as adopted by the *American Academy of Pediatrics*.

- The most current version of the *Recommended Childhood Immunization Schedule/United States*, jointly adopted by the *American Academy of Pediatrics*, the *Advisory Committee on Immunization Practices*, and the *American Academy of Family Physicians*, unless determined otherwise by the *State Department of Health Services*.
- The *Uniform Screening Panel* recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including breast cancer screening, annual cervical cancer screening, osteoporosis screening, and screening mammography. Benefits for preventive care visits include preconception and prenatal services.

Covered Health Services also include voluntary family planning and all *FDA*-approved contraceptive drugs, devices, and other products for women as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law, including but not limited to the following services:

- Office visits, examinations, patient education and counseling on contraception (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
- Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
- Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
- Follow-up services related to all *FDA*-approved contraceptive drugs, devices, and other products (including all *FDA*-approved over-the-counter drugs, devices, and other products) for women. Follow-up services include, but are not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
- Voluntary female sterilization procedures, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure).

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

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one hospital grade breast pump and double breast pump kit per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits for a hospital grade breast pump and double breast pump kit are provided taking into account the following determinations:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.
- With respect to men, additional screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.
- Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

- Routine non-pediatric eye exam services for preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
- Hearing exams to determine the need for hearing correction, for all ages.
- Screening for obesity in all adults. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including intensive, multicomponent behavioral interventions for Covered Persons with a body mass index (BMI) of 30 kg/m² or higher.

25. Prosthetic Devices

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

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

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

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

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

Benefits are available for repairs and replacement, except that:

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

26. Reconstructive Procedures

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

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

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

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

Cosmetic Procedures are excluded from coverage.

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

27. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

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

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

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

For outpatient rehabilitation 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, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Habilitative Services

Benefits for habilitative services will be covered under the same terms and conditions applied to rehabilitative services under the Policy. Habilitative services include the outpatient rehabilitation services listed above. Benefits are provided for habilitative services provided for Covered Persons when the following condition is met:

- The initial or continued treatment must not be an Unproven Service or Experimental or Investigational. This condition does not apply to Medically Necessary occupational therapy or speech therapy for a Covered Person with a diagnosis of pervasive developmental disorder or Autism Spectrum Disorder.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy,

speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

28. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

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

Benefits under this section include:

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

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

29. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.

30. Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider -based case management services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

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

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

31. Surgery - Outpatient

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

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

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

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

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

32. Temporomandibular Joint Services

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

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

Non-surgical treatment including clinical examinations, physical therapy, pharmacological therapy, oral appliances (orthotic splints), joint injections 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, and the procedure being considered for reimbursement is Medically Necessary.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

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

33. Therapeutic Treatments - Outpatient

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

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

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

Benefits under this section include:

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

34. Transplantation Services

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

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

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

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

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

35. Urgent Care Center Services

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

36. Virtual Visits

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

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

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

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

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

37. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

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

Additional Benefits Required By California Law

38. Breast Cancer Services

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

39. Dental Anesthesia Services

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

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

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

40. Mastectomy Services

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

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

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

- The drug is approved by the *FDA*.
- The drug is prescribed by a Network Physician or provider for the treatment of a chronic and seriously debilitating or Life-Threatening condition.
- The drug is Medically Necessary to treat the medical condition.
- The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

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

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

Nothing in this section shall prohibit us from use of a formulary, Copayments or Coinsurance, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the *FDA*. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

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

42. Osteoporosis Services

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

43. Phenylketonuria (PKU) Treatment

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

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

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

- Prescribed by a Physician for the treatment of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

44. Prosthetic Devices - Laryngectomy

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

45. Telehealth Services

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

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

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

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

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

B. Dental

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

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

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

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 Services*.

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

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.

3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Services*.
6. Oral appliances for snoring.
7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drugs products for use outside of a healthcare setting that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use). This exclusion does not apply if the Policy includes an Outpatient Prescription Drug Rider.
2. Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter *FDA*-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product unless Medically Necessary. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us or when Medically Necessary. Such determinations may be made up to six times during a calendar year.

Your Right to Request a Pharmaceutical Product Exclusion Exception

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

- **Urgent Requests**

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

- **External Review**

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

- **Expedited External Review**

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

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 except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under *Section 9: Defined Terms* and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is

recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

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

F. Foot Care

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

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

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

G. Medical Supplies

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

This exclusion does not apply to:

- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Services*.
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Treatment* in *Section 1: Covered Health Services*.

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

H. Mental Health and Substance Use Disorders

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

1. Services performed in connection with conditions not classified as mental disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Only Mental Health Services as treatments for R and T code conditions as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* chapters entitled "*Medication-Induced Movement Disorders and Other Adverse Effects of Medication*" and "*Other Conditions That May Be a Focus of Clinical Attention*" are excluded.
3. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
5. Transitional Living services.

I. Nutrition

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

J. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement and as required by California regulation.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Saunas.
 - Stair lifts and stair glides.
 - Strollers.
 - Safety equipment.
 - Treadmills.
 - Vehicle modifications such as van lifts.
 - Video players.
 - Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. 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.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Treatment of benign gynecomastia (abnormal breast enlargement in males). This exclusion does not apply to the reconstructive and Medically Necessary treatment of benign gynecomastia for male patients.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
4. Weight loss programs (for example, *Weight Watchers*®, *Jenny Craig*® or other structured weight loss programs) whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination 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. Psychosurgery.
5. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
6. Biofeedback.
7. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS.
8. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in *Temporomandibular Joint (TMJ) Services* under *Section 1: Covered Health Services*. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.
9. Surgical and non-surgical treatment of obesity.

10. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under *Other Health Education Services for You* in the section of the *Certificate* titled *Our Responsibilities*. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
11. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
12. In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility.

M. Providers

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

This exclusion does not apply to mammography.

N. Reproduction

1. The following infertility treatment-related services:
 - Cryo-preservation and other forms of preservation of reproductive materials.
 - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. The reversal of voluntary sterilization.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, or similar legislation. This exclusion only applies when you are legally

entitled to such other coverage and you are able to receive health services under the other coverage arrangement.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health services while on active military duty, when you are on active duty for more than 30 days.

P. Transplants

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

Q. Travel

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

R. Types of Care

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

S. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

5. Bone anchored hearing aids except when the Covered Person has either of the following:
 - Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid; or
 - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

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

T. All Other Exclusions

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

10. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

If You Are Eligible for Medicare

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

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

Who is Eligible for Coverage

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

Eligible Person

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

Eligible Persons must reside within the United States.

Dependent

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.
- All newborn Dependent children of the Subscriber are covered from the moment of birth. All newly adopted Dependent children of the Subscriber are covered from and after the moment the child is placed in the physical custody of the Subscriber for adoption. However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 90 days of the event.
- Coverage for other Dependents listed above begins on the date of the event if we receive the completed enrollment form and any required Premium within 90 days of the event that makes the other new Dependent eligible.

However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 90 days of the event.

Coverage for other Dependents listed above begins on the date of the event if we receive the completed enrollment form and any required Premium within 90 days of the event that makes the other new Dependent eligible.

Special Enrollment Period

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

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

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

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

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

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

- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits that do not constitute essential health benefits. Lifetime limits are prohibited on the dollar value of essential health benefits under a plan.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.
- Loss of minimum essential coverage, including, but not limited to, loss of eligibility for coverage as a result of the following: legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, termination of employer contributions, and exhaustion of COBRA continuation coverage; loss of coverage because the covered employee becomes eligible for Medicare; and bankruptcy of the employer from whose employment the covered employee retired; loss of coverage due to an act or practice that constituted fraud, or an intentional misrepresentation of a material fact.
- Gaining or becoming a dependent (due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship).
- State or Federal Court mandate to be covered as a Dependent.
- Release from incarceration.
- Health coverage issuer substantially violated a material provision of the health coverage contract.
- Gaining access to new health benefit plans as a result of a permanent move.
- Receiving services from a contracting provider under another health insurance plan for (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, health condition, or other medical problem that requires prompt medical attention and that has a limited duration), (b) a serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration), (c) a pregnancy, (d) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), (e) care of a newborn child between birth and age 36 months, or (f) performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health benefit plan.
- Being misinformed that one had minimum essential coverage.
- Returning from active duty of the reserve forces of the United States military or the California National Guard.

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). 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 for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

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

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

If UnitedHealthcare Insurance Company can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may rescind your coverage, with written notice of your right to appeal. No Policy will be rescinded after 24 months following the issuance of the Policy. If we rescind your coverage, we will send the Employer Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Insurance. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may cancel your coverage, as permitted by law. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions allowed by law, which may include demanding that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

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

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

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

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

Coverage for a Disabled Dependent Child

Initial Enrollment of a Disabled Dependent Child

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

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

We will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. We will send this notification to the Subscriber at least 90 days prior to the date the Enrolled Dependent child attains the limiting age. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will determine whether the Enrolled Dependent child meets the criteria before the child attains the limiting age. If we fail

to make the determination by that date, coverage of the Enrolled Dependent child will continue pending our determination.

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

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

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

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

Continued Enrollment of a Disabled Child

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

Extended Coverage for Total Disability

Coverage 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, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

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

Continuation of Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us.

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

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

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

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

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

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

Optum Rx

Attn: Claims Department

P.O. Box 29077

Hot Springs, AR 71903

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

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

Payment of Benefits

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

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

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

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

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

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

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

Section 6: Questions, Complaints and Appeals

IMPORTANT NOTICE - CLAIM DISPUTES

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

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

Call the California Department of Insurance at:

- 1-800-927 HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

A Covered Person may write the California Department of Insurance at:

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

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

IMPORTANT NOTICE - NETWORK PROVIDER ACCESSIBILITY COMPLAINTS

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

Call the California Department of Insurance at:

- 1-800-927-HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

You may write the California Department of Insurance at:

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

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

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

What to Do if You Disagree with Our Adverse Benefit Determination

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

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

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, 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 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 appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

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

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

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Non-Urgent Pre-Service Requests Based on Medical Necessity

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

- Decisions to approve, modify or deny requests for authorization of Covered Health Services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Covered Person's condition, not to exceed five business days from our receipt of the information reasonably necessary and requested to make the decision.
- If the Covered Person's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Covered Person's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Covered Person's condition, but not later than 72 hours after our receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

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

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

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be decided within 5 business days of the request.

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

Urgent Appeals that Require Immediate Action

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

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

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

Denial of Experimental, Investigational or Unproven Services

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

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.

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

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

Independent External Review Program

- If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) from the *California Department of Insurance (CDI)* at no cost to you. However, you must first file an appeal of the denial with us.
- **First Steps:** Appeal the denial using our internal appeals/grievance process.
- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

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

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

An IMR can be requested if our decision involves:

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

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

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.
2. Agree and provide written consent to participate in IMR.
3. The CDI determines if the request is eligible for IMR.
4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.

5. The IMR organization will send the decision to the Covered Person, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.

6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify the Covered Person and us. The decision is binding on UnitedHealthcare Insurance Company.

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

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

Contact the California Department of Insurance:

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

- 1-800-927 HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

You may also write the California Department of Insurance at:

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

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 based on California regulations.

When Coordination of Benefits Applies

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

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

Definitions

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

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

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

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

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

Order of Benefit Determination Rules

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

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

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care

coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

- (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

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

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

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

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

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

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

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

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

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We offer health care coverage to Eligible Persons with a physical handicap under the same terms and conditions as are offered to Eligible Persons without a physical handicap. We do not provide medical services or make treatment decisions. This means:

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

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

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

Our Relationship with Providers and Enrolling Groups

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

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

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

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

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

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan

administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount that is a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

Notice

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

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

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

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

Interpretation of Benefits

We will do the following:

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

Other persons or entities may provide services in regard to the administration of the Policy.

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

Administrative Services

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

Amendments to the Policy

To the extent permitted by law, we reserve the right to change, modify, withdraw or add Benefits or terminate the Policy.

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

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

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

Information and Records

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

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

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

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

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

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

Examination of Covered Persons

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

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

Workers' Compensation not Affected

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

Medicare Eligibility

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

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

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

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

Reimbursement - Right to Recovery

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

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
 - providing any relevant information requested by us,

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

Refund of Overpayments

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

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

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

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

Change of Beneficiary

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

Non-Discrimination in Contract Availability or Terms

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

Legal Actions

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

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

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

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Health Treatment - professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or Autism Spectrum Disorders, and that meet all of the following criteria:

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

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

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

- Provides Behavioral Health Treatment.
 - Is employed and supervised by a qualified autism service provider.
 - Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
 - Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
 - Has training and experience in providing services for pervasive developmental disorder or Autism Spectrum Disorders pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
- "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
 - Is employed and supervised by a qualified autism service provider.
 - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
 - Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
 - Has adequate education, training, and experience, as certified by a qualified autism service provider.

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

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

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

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

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

- The applicable Copayment.
- The Eligible Expense.

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

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

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

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

Custodial Care - services that are any of the following:

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

Dependent - the Subscriber's legal Spouse or a child of the Subscriber or the Subscriber's Spouse. All references to the Spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. The term child includes any of the following:

- A natural child.
- A stepchild.
- An adopted child.
- A child placed for adoption.
- Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children.

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

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

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

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

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

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

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's child, the child will be able to be enrolled regardless of any enrollment season restriction. We

will enroll the child upon application for enrollment by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

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

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

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

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

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.

Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

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

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

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

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

Domestic Partner - a person who has filed a declaration of domestic partnership with the *California Secretary of State* or a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:

- Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
- A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

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

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

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

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

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

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

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- placing the Covered Person's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:

- there is inadequate time to effect safe transfer to another Hospital prior to delivery, or
- a transfer poses a threat to the health and safety of the Covered Person or unborn child.

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

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

Emergency Health Services - with respect to an Emergency:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd*) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

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

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

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

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Life-Threatening or seriously debilitating condition, we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that health condition.
- Benefits are available for an *FDA*-approved drug prescribed for a use that is different from the use for which the *FDA* approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the

following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

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

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - ◆ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - ◆ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - ◆ A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - ◆ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - ◆ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - ◆ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
 - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
 - ◆ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 - ◆ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - ◆ A strong preference for cross-gender roles in make-believe play or fantasy play.

- ◆ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - ◆ A strong preference for playmates of the other gender.
 - ◆ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
 - ◆ A strong dislike of ones' sexual anatomy.
 - ◆ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. 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 primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

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

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

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

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

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational 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. Examples include *Applied Behavioral Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

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

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

- Fewer than seven days each week.

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

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

Life-Threatening - means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a health condition, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

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

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

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

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

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

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses.

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

Mental Illness - Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

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

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

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

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

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

Out-of-Pocket Maximum - the maximum amount that you will pay per year which includes the Annual Deductible, Copayments, or Coinsurance (as applicable). The Out-of-Pocket Maximum excludes Premiums, balance billing amounts for non-Network providers and the Covered Person's spending for non-covered services. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

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

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

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

Please Note: Any acupuncturist, audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe

a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

Pregnancy - includes all of the following:

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

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

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

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

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

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance Use Disorder Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.

- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Serious Emotional Disturbances - when a Enrolled Dependent child who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the disorder, one or more of the following is true:

- The child is at risk of removal from home or has been ill for more than six months.
- The child displays psychotic features, risk of suicide or risk of violence.
- The child meets special education eligibility requirements under state law.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Severe Mental Illness - any of the following diagnosed Severe Mental Illnesses: schizophrenia or schizoaffective disorder, bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or Autism Spectrum Disorders; anorexia nervosa; and bulimia nervosa.

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

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

Spouse - a person who is married to an Employee. All references to Spouse shall include a Domestic Partner. Please refer to the definition of *Domestic Partner*.

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

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and*

Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded.

Telehealth - means the mode of delivering Covered Health Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Health Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Health Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Total Disability or Totally Disabled - A disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Triage - Triage is the assessment of a Covered Person's health concerns and symptoms via communication, with a Physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or Triage a Covered Person who may need care, for the purpose of determining the urgency of the Covered Person's need for care. Triage or screening services are available 24 hours per day, 7 days per week.

Transitional Living - Mental health services and substance use disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

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

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

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

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

Please note:

- If you have a Life-Threatening or seriously debilitating condition, we may consider an otherwise Unproven Service to be a Covered Health Service for that health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that health condition.
- We may consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a health condition that is not a Life-Threatening or seriously debilitating condition. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

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

Urgent Request - any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the Covered Person or the ability of the Covered person to regain maximum function, or
- In the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the claimant to serve pain that cannot be adequately managed without the care or treatment that is the subject of the claim for medical care or treatment.
- In determining whether a claim for medical care or treatment involves urgent care, the individual acting on behalf of the plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Covered Person's medical condition determines that a claim involves urgent care, the claim for medical care or treatment will be treated as an urgent care claim.

Chiropractic Treatment, Durable Medical Equipment, Hospice Care, Infertility Services, Rehabilitation Services - Outpatient Therapy, Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, and Transplantation Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Section 1: Covered Health Services

1. *Hospice Care* in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

Hospice Care

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

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

2. The following provision is added to the *Certificate, Section 1: Covered Health Services*:

Chiropractic Treatment

Services provided by a Physician or licensed therapy provider for Chiropractic Treatment.

3. *Rehabilitation Services - Outpatient Therapy* in the *Certificate, Section 1: Covered Health Services* is replaced with the following:

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.

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

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

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

4. The prior authorization penalty in the *Schedule of Benefits* is modified as follows:

Prior Authorization Penalty. For Covered Health Services that prior authorization, if you fail to obtain prior authorization as required, Benefits will be reduced 50%

Schedule of Benefits

5. *Durable Medical Equipment* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Durable Medical Equipment	Prior Authorization Requirement		
<p>For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expense.</p>			
To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes

6. *Hospice Care* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Hospice Care			
Prior Authorization Requirement For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses			
Any combination of outpatient and inpatient Network and Non-Network Benefits are limited to 180 days per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. Limited to 5 respite care visits per Covered Person per year. One visit equals up to 24 hours of respite care services. Respite care visits not to exceed five consecutive days at a time.	Network 80% Non-Network 50%	Yes Yes	Yes Yes

7. *Infertility* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Infertility Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to \$15000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit does not include Physician office visits for the treatment	Network 80% for diagnosis and testing	Yes	Yes

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
of infertility for which Benefits are described under Physician's Office Services - Sickness and Injury below	80% for treatment, including medications and surgery Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.

8. The provision below for *Chiropractic Treatment* is added to the **Schedule of Benefits** and the following bulleted item is added to the *Schedule of Benefits* as a Covered Health Service which requires prior authorization under Covered Health Services which Require Prior Authorization:

- Chiropractic Treatment.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Chiropractic Treatment			
Limited to 12 visits of Chiropractic Treatment services per year.	Network 80% Non-Network 50%	Yes Yes	Yes Yes

9. *Rehabilitation Services - Outpatient Therapy* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Rehabilitation Services - Outpatient Therapy			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required,			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits will be reduced to 50% of Eligible Expenses.			
<p>Any combination of Outpatient Rehabilitation Services is limited to 30 visits per year.</p> <p>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.</p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>Non-Network Benefits are not available.</p>	<p>Yes</p> <p>Non-Network Benefits are not available.</p>	<p>Yes</p> <p>Non-Network Benefits are not available.</p>

10. *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p align="center">Prior Authorization Requirement</p> <p>For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
<p>Limited to:</p> <ul style="list-style-type: none"> • 30 days per year in a Skilled Nursing Facility. • 30 days per year in an Inpatient Rehabilitation Facility. 	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>

11. *Transplantation Services* in the *Schedule of Benefits* is replaced with the provision below:

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Transplantation Services			
<p>Prior Authorization Requirement</p> <p>For Network Benefits you must obtain prior authorization as soon as reasonably possible if a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses</p>			
<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p>	<p>Network</p> <p>80%</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>

Section 2: Exclusions and Limitations

12. The exclusion for respite care in the *Certificate* under *Section 2: Exclusions and Limitations, Types of Care* is replaced with the following:

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 Services*.

Section 9: Defined Terms

13. The definition of *Manipulative Treatment* in the *Certificate* under *Section 9: Defined Terms* is replaced with the following:

Chiropractic Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

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

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires notification/prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Schedule of Benefits or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements.

Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating the Covered Person's condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate.

If the Covered Person's Physician determines that a Prescription Drug Product or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating the Covered Person's condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com.

If the Covered Person is changing policies, we will not require the Covered Person to repeat step therapy when the Covered Person is already being treated for a medical condition by a Prescription Drug Product

provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Covered Person's medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Covered Person's medical condition.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in *Prior Authorization Requirements* of this *Outpatient Prescription Drug Schedule of Benefits*.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.
- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Copayment/Coinsurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Specialty Prescription Drug Products</p>	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$5.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$20.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$35.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed \$200 for an individual prescription of up to a 30-day supply</p> <p>Non-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$5.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$20.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$35.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed \$200 for an individual prescription of up to a 30-day supply
Prescription Drugs from a Retail Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to twelve cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$5.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$20.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$35.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed \$200 for an individual prescription of up to a 30-day supply</p>
Prescription Drugs from a Retail Non-Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to twelve cycles at one time if you 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$5.00 per Prescription Order or Refill.</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>pay a Copayment and/or Coinsurance for each cycle supplied.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$20.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$35.00 per Prescription Order or Refill. However, you will not pay more than \$250 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed \$200 for an individual prescription of up to a 30-day supply</p>
<p>Prescription Drug Products from a Mail Order Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. <p>We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$10.00 per Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40.00 per Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$70.00 per Prescription Order or Refill. However, you will not pay more than \$750 per Prescription Order or Refill.</p> <p>For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed \$200 for an individual prescription of up to a 30-day supply.</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>You may be required to fill an initial Prescription Drug Product order and obtain 2 refills through a retail pharmacy prior to using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an *FDA*-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Limitation on Selection of Pharmacies

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

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other 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, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

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

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

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

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

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

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including 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, other than the diabetic supplies and inhaler spacers specifically stated as covered. This exclusion does not apply to vitamins that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* that are required to be covered under the *Patient Protection and Affordable Care Act (PPACA)*.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Service unless Medically Necessary.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to prescribed over-the-counter *FDA*-approved contraceptives or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of a health condition, except as described under *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services*.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product unless Medically Necessary. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
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 unless Medically Necessary. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Dental products, including but not limited to prescription fluoride topicals.
29. A Prescription Drug Product with an approved biosimilar or 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 showing that it is highly similar to a reference product (a biological Prescription Drug Product) and 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, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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

Your Right to Request an Exclusion Exception

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

Urgent Requests

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

External Review

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

Expedited External Review

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

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 including, but not limited to, data sources such as Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to

which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication 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 pursuant to a Prescription Order or Refill.

A Prescription Drug Product includes a drug approved by the *U.S. Food and Drug Administration*, which is prescribed for a use that is different from the use for which the *U.S. Food and Drug Administration* approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must be recognized for the specific treatment for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology*, *National Comprehensive Cancer Network Drug and Biologics Compendium*, or *Thomson Microdex DrugDex*; or (3) it is recommended by two articles from major peer reviewed medical journals. However, there is no coverage for any drug that the *U.S. Food and Drug Administration* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

A Prescription Drug Product includes a drug approved by the *U.S. Food and Drug Administration* prescribed to treat cancer during certain clinical trials as described in the *Certificate of Coverage*.

A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Disposable devices which are Medically Necessary for the administration of a covered outpatient Prescription Drug Product.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors. This does not include 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 permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for infertility. Specialty Prescription Drug Product include orally administered anticancer medications used to kill or slow the growth of cancerous cells. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

Benefits are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Covered Persons 18 years of age or older.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like additional information regarding these Covered Health Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or *Customer Care* at the number shown on your ID card.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

Language Assistance Services

We¹ provide free language services. We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-633-2446.

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 **русском (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè 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)**, udostępniłmy 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 निःशुल्क 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។ សូមទូរស័ព្ទ ទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjij' 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.

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare 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 when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

¹For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:
 - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.
 - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.
 - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26.

During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (<http://www.dol.gov/ebsa/healthreform/> - click link for Consumer Assistance Programs).

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for non-grandfathered small group Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Effective for grandfathered small group Policies that are new or renewing on or after July 1, 2010, Benefits for mental health conditions and substance use conditions that are Covered Health Services under the Policy will be revised to align prior authorization requirements and excluded services listed in your *Certificate* with Benefits for other medical conditions.

Effective for grandfathered and non-grandfathered large group Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental

health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

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

Your request should include:

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

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018:

We² are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health 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 reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration 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 use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets 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 necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified 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. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 1. HIV/AIDS;
 2. Mental health;
 3. Genetic tests;
 4. Alcohol and drug abuse;
 5. Sexually transmitted diseases and reproductive health information; and
 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

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 contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

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 Connecticut, Inc.; 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.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; 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.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

We³ are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- 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; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the *UnitedHealth Group Customer Call Center* 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: Alere Women's and Children's Health, LLC; AmeriChoice Health Services,*

Inc.; Connexions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. 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.

UNITED HEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual	WA

who is the subject of the information.	
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Enrolling Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: County of Los Angeles Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

County of Los Angeles
3333 Wilshire Blvd.
Suite 1000
Los Angeles, CA 90010
(213) 738-2255

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has delegated 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 delegated 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): 95-6000927

Plan Number: 502

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

County of Los Angeles
3333 Wilshire Blvd.
Suite 1000
Los Angeles, CA 90010
(213) 738-2255

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
860-702-5000

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 pursuant 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.

