UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company of Illinois

Certificate of Coverage

For

the Plan BKO5

of

City of Fairview Heights, IL

Group Number: 911232

Effective Date: May 1, 2020

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UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company of Illinois

Schedule of Benefits

How Do You Access Benefits?

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

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

Emergency Health Care Services are always paid as Network Benefits. You will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

Covered Health Care Services that are provided at a Network Hospital or ambulatory surgical treatment center by an out-of-Network radiologist, anesthesiologist, pathologist, Emergency Physician or neonatologist, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described at the end of this *Schedule of Benefits*. You will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts. State law prohibits such provider from balance billing you if you have assigned Benefits to such provider and have not specifically rejected assignment of benefits in writing in accordance with 215 ILCS 5/356z.3a.

However, Covered Health Care Services that are provided at a Network facility by other facility based out-of-Network providers, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. As a result, you will be responsible for the difference between the amount billed by the provider and the Allowed Amount. The payments you make to facility based out-of-Network providers for charges above the Allowed Amount does not apply towards any applicable Out-of-Pocket Limit.

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

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

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

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

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of an out-of-Network provider for a covered service in non-emergency situations, Benefit payments to such out-of-Network providers are not based upon the amount billed. The basis of your Benefit payment will be determined according to your *Certificate's* fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the *Certificate*. YOU CAN EXPECT TO PAY MORE THAN THE CO-INSURANCE AMOUNT

DEFINED IN THE CERTIFICATE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Out-of-Network providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of the *Illinois Insurance Code*. Network providers have agreed to accept discounted payments for services with no additional billing to the member other than Co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling us at the telephone number on your ID card.

Does Prior Authorization Apply?

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

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

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

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

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

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

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

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

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a Policy year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	***Network*** $250 per Covered Person, not to exceed $500 for all Covered Persons in a family. ***Out-of-Network*** $250 per Covered Person, not to exceed $500 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit	***Network*** $1,550 per Covered Person, not to exceed $3,500 for all Covered

Payment Term And Description	Amounts
applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. • Co-payments or Co-insurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit.	Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $2,250 per Covered Person, not to exceed $4,500 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Emergency Ambulance	***Network*** *Ground Ambulance* 10%	Yes	Yes
	Air Ambulance 10%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as appropriate.	***Network*** *Ground Ambulance* 10%	Yes	Yes
	Air Ambulance 10%	Yes	Yes
	Out-of-Network *Ground Ambulance* 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Air Ambulance 30%	Yes	Yes
2. Cellular and Gene Therapy			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid. Out-of-Network Benefits will apply. For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
3. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	***Network*** 10% ***Out-of-Network*** 30%	Yes Yes	Yes Yes
5. Dental Services - Accident Only			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	10% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must purchase, rent, or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-	***Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after receiving notice of the date a transfer is medically appropriate, Benefits will convert to the out-of-Network Benefit level for the remainder of the stay. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.	$100 per visit. ***Out-of-Network*** Same as Network	Yes Same as Network	No Same as Network
9. Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

You must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*.		
10. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as possible for non-scheduled admissions (including Emergency admissions).			
For Dependents under 19 years of age, no limits apply. Inpatient services are limited per year as follows: • Limits will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Outpatient therapies: • Physical therapy. • Occupational therapy.	*Outpatient* $10 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*. Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.	***Out-of-Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
	Outpatient 30%	Yes	Yes
11. Hearing Aids			
Benefits are limited to one hearing instrument per hearing impaired ear every 36 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.	***Network*** 10%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
12. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
13. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
14. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as possible for non-scheduled admissions (including Emergency admissions).			
	Network 10% ***Out-of-Network*** 30%	 Yes Yes	 Yes Yes
15. Infertility Services			
Prior Authorization Requirement You must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Benefits for Assisted Reproductive Technology (ART) are limited to four	***Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.	10%	Yes	Yes
	Out-of-Network		
	30%	Yes	Yes
16. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Lab Testing - Outpatient	***Network***		
Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	None	Yes	No
	Out-of-Network		
	30%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network***		
	None	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
17. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
18. Mental Health Care and Substance Use Disorders Services			
Prior Authorization Requirement **Mental Health Care Services** For Out-of-Network Benefits for a scheduled admission for Mental Health Care Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as possible for non-scheduled admissions (including Emergency admissions). In addition, for Out-of-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; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis* (*ABA*).			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. **Substance Use Disorders Services** Substance Use Disorder Services are not subject to prior authorization requirements; however, your provider or facility must provide notification of the initiation of treatment within two business days following admission. If your provider or facility fails to notify us of the initiation of treatment, we may follow our normal prior authorization processes as set forth below. For Out-of-Network Benefits for an admission for Substance Use Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain authorization as soon as possible following admission. In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received or as soon as possible after the date you receive the following services: Partial Hospitalization/Day Treatment; Intensive 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. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
	Network *Inpatient* 10% *Outpatient* $10 per visit 10% for Partial Hospitalization/Intensive Outpatient Treatment ***Out-of-Network***	 Yes Yes Yes	 Yes No Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Inpatient 30%	Yes	Yes
	Outpatient 30%	Yes	Yes
	30% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
19. Ostomy Supplies			
Limited to $2,500 per year.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
20. Pharmaceutical Products - Outpatient			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
21. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
22. Physician's Office Services - Sickness and Injury			
In addition to the office visit Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and*	***Network*** **For Covered Persons under the age of 19:** None per visit for a Primary Care Physician office visit or $10 per visit for a Specialist office visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	**For Covered Persons age 19 and older:** $10 per visit for a Primary Care Physician office visit or $10 per visit for a Specialist office visit	Yes	No
	Out-of-Network 30%	Yes	Yes
23. Pregnancy - Maternity Services			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization as soon as possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.

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

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. ***Out-of-Network*** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
24. Preventive Care Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Physician office services	***Network*** None	No	No
	Out-of-Network 30%	Yes	Yes
Lab, X-ray or other preventive tests	***Network*** None	No	No
	Out-of-Network 30%	Yes	Yes
Breast pumps	***Network*** None	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 30%	Yes	Yes
25. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
26. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as possible for non-scheduled inpatient admissions (including			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Emergency admissions).			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
27. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 60 visits of physical therapy for multiple sclerosis. • 20 Manipulative Treatments. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	***Network*** $10 per visit	Yes	No
	Out-of-Network 30%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
28. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
29. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as possible for non-scheduled admissions (including Emergency admissions).			
Limited to 60 days per year.	***Network*** 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
30. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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 possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
31. Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before TMJ or CMD services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
32. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000.			
	Network 10%	Yes	Yes
	Out-of-Network 30%	Yes	Yes
33. Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid. Out-of-Network Benefits will apply. For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not	***Network*** Depending upon where the Covered Health Care 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 Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
34. Urgent Care Center Services			
In addition to the Co-payment stated in this section, the Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under	***Network*** $35 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Therapeutic Treatments - Outpatient.	***Out-of-Network*** 30%	Yes	Yes
35. Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	***Network*** $10 per visit	Yes	No
	Out-of-Network 30%	Yes	Yes
Additional Benefits Required By Illinois Law			
36. Amino Acid-Based Elemental Formulas			
	Network 10% or as stated under the *Outpatient Prescription Drug Schedule of Benefits.*	Yes	Yes
	Out-of-Network 30% or as stated under the *Outpatient Prescription Drug*	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Schedule of Benefits.		
37. Dental Services - Anesthesia and Facility			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under the applicable Covered Health Care Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
38. Examination and Treatment for Sexual Assault			
	None	No	No

Allowed Amounts

Allowed Amounts are the amounts determined to be payable for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, Emergency Health Care Services provided at a Network Hospital or Network ambulatory surgical treatment center by an out-of-Network Emergency Physician or other Emergency department provider, or Covered Health Care Services that are provided at a Network Hospital or Network ambulatory surgical treatment center by an out-of-Network radiologist, anesthesiologist, pathologist, or neonatologist, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills and you will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

For Covered Health Care Services provided by an out-of-Network facility based Physician that is not addressed in the prior paragraph (other than Emergency Health Care Services or services otherwise arranged by us), you will be responsible to the out-of-Network facility based Physician for any amount billed that is greater than the amount determined to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*. However, if we are required to pay a higher amount to an out-of-Network Emergency Physician or other Emergency department provider, radiologist, anesthesiologist, pathologist, or neonatologist in accordance with Illinois law, then that higher amount is the Allowed Amount.

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

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

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

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on:
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:
    - Allowed Amounts are 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 for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

- For Mental Health Care and Substance Use Disorders Services the Allowed Amount will be reduced by 25% for Covered Health Care Services provided by a psychologist and by 35% for Covered Health Care Services provided by a masters level counselor.

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

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here, unless such services are provided at a Network Hospital or Network ambulatory surgical treatment center by an out-of-Network Emergency Physician or other emergency department provider, radiologist, anesthesiologist, pathologist, or neonatologist and you have assigned benefits to such provider and have not specifically rejected assignment of benefits in writing in accordance with 215 ILCS 5/356z.3a.

For Covered Health Care Services received at a Network Hospital or Network ambulatory surgical treatment center on a non-Emergency basis from an out-of-Network facility based Physician, the Allowed Amount 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.
- If we are required to pay a higher amount to an out-of-Network Emergency Physician or other Emergency department provider, radiologist, anesthesiologist, pathologist, or neonatologist in accordance with Illinois law, then that higher amount is the Allowed Amount.

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 Allowed Amount is based on 20% of the provider's billed charge.

For Mental Health Care and Substance Use Disorders Services the Allowed Amount will be reduced by 25% for Covered Health Care Services provided by a psychologist and by 35% for Covered Health Care Services provided by a masters level counselor.

IMPORTANT NOTICE: Out-of-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Allowed Amount described here, unless such services are provided at a Network Hospital or Network ambulatory surgical treatment center by an out-of-Network Emergency Physician or other emergency department provider, radiologist, anesthesiologist, pathologist, or neonatologist and you have assigned benefits to such provider and have not specifically rejected assignment of benefits in writing in accordance with 215 ILCS 5/356z.3a.

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

Provider Network

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

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

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

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

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

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

Designated Providers

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

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

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

available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

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

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider. You will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

Limitations on Selection of Providers

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

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

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

Certificate of Coverage

UnitedHealthcare Insurance Company of Illinois

185 Asylum Street

Hartford, CT 06103

(860) 702-5000

200 East Randolph Street, Ste 5300

Chicago, IL 60601

(312) 803-5900

What Is the Certificate of Coverage?

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

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

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

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

What is the Entire Contract?

The Policy, including the application and any Amendments and Riders, constitutes the entire contract of insurance. No change is valid unless approved by an executive officer of UnitedHealthcare Insurance Company of Illinois and unless such approval be endorsed hereon or attached hereto.

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

We are delivering the Policy in Illinois. The Policy is subject to the laws of the state of Illinois and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Illinois law governs the Policy.

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

You may select a woman's principal health care provider in addition to your selection of a Primary Care Physician. A woman's principal health care provider is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. If you do not obtain prior authorization, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $1,000. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician,

provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

To the extent allowed by law, we have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Emergency Services Incurred by Out-of-Network Providers

For Emergency Health Care Services or services arranged by us, you will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

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

Offer Health Education Services to You

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

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

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

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

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

1. Ambulance Services

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities only when the transport meets one of the following:

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

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

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

2. Cellular and Gene Therapy

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

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

3. Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine patient care costs for Qualifying Clinical Cancer Trials include:

- Covered Health Care Services provided in the Qualified Clinical Cancer Trial that are otherwise generally covered under the Policy.
- Covered Health Care Services consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality that a provider typically provides to a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.

Routine costs for clinical trials do not include:

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

Routine patient care costs for Qualifying Clinical Cancer Trials do not include:

- A health care service, item or drug that is the subject of the cancer clinical trial.
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the Qualified Clinical Cancer Trial that is not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the *U.S. Food and Drug Administration*.
- Transportation, lodging, food or other expenses for the patient, family member or companion of the patient that are associated with the travel to or from the facility providing the cancer clinical trial, unless the Policy covers these expenses for a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.
- A health care service, item, or drug customarily provided by the Qualified Clinical Cancer Trial sponsors free of charge for any patient.
- A health care service or item, which except for the fact that it is being provided in a Qualified Clinical Cancer Trial, is otherwise specifically excluded from coverage under the Policy, including:
  - Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that you are participating in the cancer clinical trial; and
  - Costs of non-health care services that the patient is required to receive as the result of participation in the approved cancer clinical trial.
- Costs for services, items or drugs that are eligible for reimbursement from a source other than a patient's contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial.
- Costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology, unless the Policy covers these expenses for a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.

- A health care service or item that is eligible for reimbursement by a source other than the Policy, including the sponsor of the Qualified Clinical Cancer Trial.

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

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

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

4. Congenital Heart Disease (CHD) Surgeries

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

- Coarctation of the aorta.

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

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

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

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

5. Dental Services - Accident Only

Dental services, including dental ancillary services, when all of the following are true:

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

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

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within 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 accidental Injury are limited to the following:

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

6. Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, including medical nutrition therapy services and education programs that allow the patient to maintain an A1c level within the range identified in nationally recognized standards of care. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

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

Diabetic Self-Management Items

Insulin pumps and supplies, continuous glucose monitors, blood glucose monitors for the legally blind, and cartridges for the legally blind for the management and treatment of diabetes, based upon your medical needs. The items listed above are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets, lancets and lancet devices, glucagon emergency kits, and *FDA*-approved oral agents used to control blood sugar are described under the *Outpatient Prescription Drug Rider*.

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

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

DME and Supplies

Examples of DME and supplies include:

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

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

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

Orthotics and Customized Orthotic Devices

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

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

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

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

8. Emergency Health Care Services - Outpatient

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

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

For Emergency Health Care Services received from an out-of-Network Physician or provider, you will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

Benefits 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 provided by or under the direction of a Physician.

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

10. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition, or children with congenital, genetic, or early acquired disorders to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

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

- Cognitive therapy.
- Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age.

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

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

The following are not habilitative services:

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

We may require the following be provided:

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

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a Treatment Plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of Treatment Plan updates.

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

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

11. Hearing Aids

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

Benefits are available for a hearing instrument that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing instrument and related services, including audiological exams and selection, fitting, and adjustment of ear molds to maintain optimal fit.

Hearing instruments include any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

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

Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in the *Certificate*.

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

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

12. Home Health Care

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

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

To determine the availability of Benefits, both the skilled nature of the service and the need for Physician-directed medical management will be reviewed.

13. Hospice Care

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

- Short-term grief counseling for immediate family members while you are receiving hospice care.
- Coordinated home care.
- Medical supplies and dressings.
- Medication.
- Nursing services - skilled and non-skilled.
- Occupational therapy.
- Pain management services.
- Physical therapy.
- Physician visits.
- Psychological.
- Social and spiritual services.
- Respite care service.

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

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

14. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- A stay following a covered mastectomy for the length of time determined as medically appropriate by the attending Physician and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Covered Person and the availability of a post-discharge Physician's office visit or in-home nurse visit to verify the condition of the Covered Person in the first 48 hours after discharge.

15. Infertility Services

Benefits include Infertility services for a Covered Person who is 18 years of age or older.

Coverage is provided for the diagnosis and treatment of Infertility, including:

- In vitro fertilization (IVF).

- Uterine embryo lavage.
- Embryo transfer.
- Artificial insemination.
- Gamete intrafallopian tube transfer (GIFT).
- Zygote intrafallopian tube transfer (ZIFT).
- Low tubal ovum transfer.

The coverage provided above is subject to the following conditions:

Benefits are provided for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer only if:

- The Covered Person has been unable to attain or sustain a successful Pregnancy through reasonable, less costly medically appropriate Infertility treatments for which coverage is available under the Policy, plan or contract; and
- The procedures are performed at facilities conforming to *The American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics or to the *American Fertility Society* minimal standards for programs of in vitro fertilization.

Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.

Benefits include Medically Necessary standard fertility preservation services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility.

In the event a voluntary sterilization is successfully reversed, Infertility Benefits will be available if the Covered Person's diagnosis meets the definition of Infertility.

Benefits do not include any of the following:

- Non-medical costs of donor eggs and donor sperm.
- Travel costs for travel within 100 miles of the Covered Person's home address, travel costs not necessary, not mandated or required by us.
- Infertility treatments deemed experimental in nature. However, when Infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be separately charged, those services which are not experimental in nature will be considered a Covered Health Care Service.

Donor Expenses

Benefits include medical expenses of an oocyte or sperm donor for procedures to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the Covered Person. Associated donor medical expenses, including but not limited to physical exam, laboratory screening, psychological screening, and prescription drugs, will also be covered if established as prerequisites to donation by us.

Coverage will not be excluded for a known donor. In the event the Covered Person does not have arrangements with a known donor, we may require the use of a contracted facility. If the Covered Person uses a known donor, we may require the use of contracted providers by the donor for all medical treatment, including, but not limited to, testing, prescription drug therapy and ART procedures, if Benefits are dependent upon the use of such contracted providers.

16. Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
- Allergy testing.
- An annual cervical smear or Pap smear test.
- Surveillance tests for ovarian cancer for women who are at risk for ovarian cancer. "At risk for ovarian cancer" means:
    - Having a family history:
        - With one or more first-degree relatives with ovarian cancer.
        - Of clusters of women relatives with breast cancer.
        - Of nonpolyposis colorectal cancer.
    - Testing positive for BRCA1 or BRCA2 mutations.
- An annual digital rectal exam and a prostate specific antigen test upon the recommendation of a Physician for any of the following:
    - Asymptomatic men age 50 and over.
    - African-American men age 40 and over.
    - Men age 40 and over with a family history of prostate cancer.
- Bone density tests including bone mass measurements and diagnosis and treatment of osteoporosis.

Preventive screenings included in the comprehensive guidelines supported by the *Health Resources and Services Administration* are described under *Preventive Care Services*.

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

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

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

17. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

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

18. Mental Health Care and Substance Use Disorders Services

Mental Health Care and Substance Use Disorders (also referred to 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.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Psychological testing.
- Neuropsychological testing.
- Electroconvulsive therapy.
- Detoxification programs.
- Acute treatment services.
- Clinical stabilization services.

- Mental Health Care Services, including Diagnosis of Autism Spectrum Disorders and Treatment for Autism Spectrum Disorders (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

If Substance Use Disorder Services are determined to no longer be Medically Necessary, we will provide notification in writing to you and your provider of your right to request an external review within 24 hours following the adverse determination. You or your authorized representative may request an expedited external review within 24 hours after receipt of the adverse determination notification. Refer to *Section 6: Questions, Complaints and Appeals* for additional information regarding your expedited external review rights.

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

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

19. 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.

20. Pharmaceutical Products - Outpatient

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

Benefits are available for treatment with immune gamma globulin therapy when diagnosed with a primary immunodeficiency and prescribed as Medically Necessary by a Physician.

Benefits include the use of intravenous immunoglobulin therapy for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS).

Benefits are provided for Pharmaceutical Products which, due to their traits, are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the

Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

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

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

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

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

21. Physician Fees for Surgical and Medical Services

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

22. Physician's Office Services - Sickness and Injury

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

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

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

Covered Health Care Services include:

- Genetic Counseling.
- Allergy injections.
- Clinical breast exams:
  - At least every three years for women between the ages of 20 and 40.
  - Annually for women age 40 and older.

- Treatment for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless medical history is able to confirm a chronic, relapsing, symptomatic breast condition.
- Treatment for breast cancer Pain Therapy. Medically Necessary breast cancer pain medication is covered under *Pharmaceutical Products-Outpatient* or the *Outpatient Prescription Drug Rider*.
- Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS), including, but not limited to, the use of intravenous immunoglobulin therapy. Benefits for intravenous immunoglobulin therapy are described under *Pharmaceutical Products - Outpatient*.
- Additional surgical opinion following a recommendation for elective surgery. Benefits will be limited to one consultation and related diagnostic services by a Physician.
- Telehealth services for licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetic Covered Persons in the home.

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

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

23. Pregnancy - Maternity Services

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

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

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

Benefits include prenatal HIV testing when ordered by an attending Physician, a physician assistant or an advanced practice registered nurse. Orders must be consistent with the recommendations of the *American College of Obstetricians and Gynecologists* or the *American Academy of Pediatrics*.

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. An earlier discharge may be provided if based on evaluation and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the newborn in the first 48 hours after discharge. A shorter length stay must meet the protocols and guidelines for the length of a Hospital Inpatient Stay as developed by the *American College of Obstetricians and Gynecologists* or the *American Academy of Pediatrics*.

If the newborn child needs treatment for a Sickness, Injury, Congenital Anomaly or a premature birth, Benefits will be available for that care from the moment of birth. Please refer to *Section 3: When Coverage Begins* for additional information on adding your newborn to the Policy.

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.*
- 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.*

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

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits are determined based on the following:

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

The preventive care services described in this section may change as the *United States Preventive Services Task Force,* the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,* and the *Health Resources and Services Administration* guidelines are modified. You may access more information and details about coverage of these preventive health care services by contacting us at www.myuhc.com or the telephone number on your ID card.

Preventive health care services for adults

Benefits under this section include the following when required by federal law:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use counseling to prevent cardiovascular disease for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults ages 40 to 75 years.
- Colorectal cancer screening for adults starting at age 50 years and continuing until age 75 years.
- Depression screening for adults.
- Diabetes (Type 2) screening for adults ages 40 to 70 years who are overweight or obese.

- Diet counseling for adults at higher risk for chronic disease.
- Falls prevention using exercise interventions in community-dwelling adults 65 years or older who are at increased risk for falls.
- Hepatitis B screening for adults at high risk.
- Hepatitis C virus infection screening for adults at high risk and adults born between 1945 and 1965.
- HIV screening for persons ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary:
    - Haemophilus influenzae type b (HIB): 1 or 3 doses for at risk adults at any age depending on indication.
    - Hepatitis A.
    - Hepatitis B.
    - Herpes zoster (shingles).
    - Human papillomavirus.
    - Influenza (flu shot).
    - Measles, Mumps, Rubella.
    - Meningococcal.
    - Pneumococcal.
    - Tetanus, Diphtheria, Pertussis.
    - Varicella.
- Latent tuberculosis infection screening for adults ages 18 years and older that are at increased risk.
- Lung cancer screening, once per year, with low-dose computed tomography for adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years, but not for adults who have not smoked for 15 years or have developed a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Obesity screening and counseling for all adults.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer for young adults, up to 24 years, who have fair skin.
- Syphilis screening for adults at higher risk.
- Tobacco use screening for all adults and cessation interventions for tobacco users.

Preventive health care services for women

Benefits under this section include the following when required by federal law:

- Asymptomatic bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.

- Breast cancer chemoprevention counseling for women at higher risk.
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 1 to 2 years for women over 40.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women ages 21 to 65 years.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, for all pregnant women aged 24 and younger, and for all older women who are at increased risk.
- Contraception - *U.S. Food and Drug Administration* approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including over the counter or prescription drugs, or pharmaceutical products).
- Domestic and interpersonal violence screening and counseling for all women.
- Folic Acid supplement use counseling for women who may become pregnant.
- Gestational diabetes mellitus screening in asymptomatic pregnant women after 24 weeks of gestation.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in women 65 years and older and postmenopausal women younger than 65 who are at increased risk of osteoporosis.
- Preeclampsia screening with blood pressure measurements for pregnant women throughout Pregnancy.
- Rh (D) blood typing and antibody testing for all pregnant women during their first visit for Pregnancy-related care and repeated Rh (D) antibody testing for all un-sensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.
- Sexually Transmitted Infections counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Well-woman visits.

Preventive health care services for children

Benefits under this section include the following when required by federal law:

- Alcohol misuse screening and intervention for adolescents.
- Anticipatory guidance: annually for children 3 years and older; more often if under 3.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Blood pressure screening for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Cervical dysplasia screening starting at age 21 years.
- Congenital hypothyroidism screening for newborns.
- Critical congenital heart defect screening for newborns.
- Dental cavities prevention for infants and children up to age 5 years where primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
- Depression screening for adolescents.
- Developmental screening for children under age 3.
- Developmental surveillance periodically for newborns to age 15 months and annually age 2 to 21.
- Dyslipidemia screening for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Fluoride chemoprevention supplements use counseling for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for non-pregnant adolescents at high risk for infection.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis.
    - Haemophilus influenzae type b.
    - Hepatitis A.
    - Hepatitis B.
    - Human papillomavirus.

- Inactivated poliovirus.
- Influenza (flu shot).
- Measles, Mumps, Rubella.
- Meningococcal.
- Pneumococcal.
- Rotavirus.
- Varicella.

- Intimate partner violence screening for women of childbearing age.
- Iron supplement use counseling for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development as provided for in the comprehensive guidelines supported by *HRSA*.
- Obesity screening and counseling.
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer for children, adolescents, and young adults, ages 6 months to 24 years, who have fair skin.
- Tobacco use interventions for children and adolescents, including education or brief counseling, to prevent initiation of tobacco use.
- Tuberculin testing for children at higher risk of tuberculosis as provided for in the comprehensive guidelines supported by *HRSA*.
- Vision screening for all children as provided for in the comprehensive guidelines supported by *HRSA*.

Illinois mandated preventive health care services

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

- Contraceptive services-
  - All contraceptive drugs, devices, and other products approved by the *FDA*. Including all *FDA* approved methods of over-the-counter drugs, devices, and products, excluding male condoms. Note that contraceptive medications which you obtain from a pharmacy are covered under the *Outpatient Prescription Drug Rider*.
  - Contraceptive services, patient education, and counseling on contraception.
  - Follow-up services related to contraceptive drugs, devices, products, and procedures.
- Screening by Low-dose Mammography which includes, but is not limited to:

- A baseline mammogram for women who are 35-39 years of age.
- An annual mammogram for women age 40 and over.
- A mammogram at the age and intervals considered to be Medically Necessary by the woman's Physician for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
- A comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.
- A screening MRI when Medically Necessary, as determined by a Physician licensed to practice medicine in all of its branches.

Benefits for screenings that do not meet the criteria above are described under the applicable Covered Health Care Services category in this *Certificate*.

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 prostheses as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

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

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

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

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

26. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures, except

in the case of newborn children diagnosed with congenital defects or birth abnormalities. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry.

Benefits include breast implant removal of an existing breast implant when the removal is Medically Necessary for a Sickness or Injury following a mastectomy. Benefits do not include the removal of breast implants that were implanted solely for cosmetic reasons.

Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

27. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Preventive Physical Therapy for multiple sclerosis.
- 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 or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

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

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

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, 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 stroke.

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.

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Colorectal cancer screenings in accordance with the published *American Cancer Society* guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by the nationally recognized professional medical societies or federal government agencies, including the *National Cancer Institute,* the *Centers for Disease Control and Prevention*, and the *American College of Gastroenterology*. Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.

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

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

To determine the availability of Benefits, both the skilled nature of the service and the need for Physician-directed medical management will be reviewed.

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

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

30. Surgery - Outpatient

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

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

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

Benefits include:

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

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

31. Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services

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

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

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

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

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.

- Open or closed reduction of dislocations.

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

32. Therapeutic Treatments - Outpatient

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

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

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

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

Benefits include:

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

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

33. Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

- Cornea.

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

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

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

34. Urgent Care Center Services

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

35. Virtual Visits

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

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

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

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

Additional Benefits Required By Illinois Law

36. Amino Acid-Based Elemental Formulas

Benefits for Amino Acid-Based Elemental Formulas when the prescribing Physician has issued a written order stating that the formula is Medically Necessary for the diagnosis and treatment of:

- Eosinophilic Disorders; and
- Short bowel syndrome.

37. Dental Services - Anesthesia and Facility

Services for general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of a dental condition. Services are limited to a Covered Person who:

- Is six years of age and under;

- Has one or more medical conditions that require hospitalization or general anesthesia for dental care; or
- Is a person with a disability.

Services for general anesthesia provided by a dentist who has obtained a permit for the administration of anesthetics under the *Illinois Dental Practice Act*, in conjunction with dental care that is provided to a Covered Person in a dental office, oral surgeon's office, hospital or ambulatory surgical treatment center will be provided if the Covered Person:

- Is under age 19; and
- Has been diagnosed with an Autism Spectrum Disorder or a disability.

Note: A Covered Person must make two visits to the dental care provider before accessing this coverage.

38. Examination and Treatment for Sexual Assault

Benefits include the exam and testing of a victim of a criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection. Benefits also include exam and treatment of injuries and trauma sustained by the victim.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

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

   This exclusion does not apply to accident-related dental services or dental anesthesia and associated hospital or alternate facility charges for which Benefits are provided as described under *Section 1: Covered Health Care Services*.

   This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral bacterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

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

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

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

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.

D. Drugs

Please note that these exclusions apply only to those services identified in *Section 1: Covered Health Care Services*. Benefits for outpatient prescription drugs and related exclusions appear in *the Outpatient Prescription Drug Rider* and the *Outpatient Prescription Drug Schedule of Benefits*.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription drugs for Infertility as described under *Infertility Services* in *Section 1: Covered Health Care Services.*
2. Self-injectable medications. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter *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 Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.
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. 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.

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. Such determinations may be made up to six times during a calendar year.

11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

E. Experimental or Investigational or Unproven Services

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

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

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Shoes.

7. Shoe orthotics.

8. Shoe inserts.

9. Arch supports.

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services*.

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.

4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

H. Mental Health Care and Substance Use Disorders

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

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders*, *Diagnostic and Statistical Manual of the American Psychiatric Association* or under Illinois law 215 ILCS 5/370c.

2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* or under Illinois law 215 ILCS 5/370c.

3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders. This exclusion does not apply to services for Autism Spectrum Disorders for which Benefits are provided as described under *Section 1: Covered Health Care Services*.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to services for Autism Spectrum Disorders for which Benefits are provided as described under *Section 1: Covered Health Care Services*.

5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living 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 Amino Acid-Based Elemental Formulas or medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.

3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

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 as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
   - 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.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.

5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

6. Habilitative services for maintenance/preventive treatment.

7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.

8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.

9. Biofeedback.

10. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

12. Surgical and non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary tobacco cessation programs, except those described under *Preventive Care Services* in *Section 1*: *Covered Health Care Services*. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

15. Helicobacter pylori (*H. pylori*) serologic testing.

16. Intracellular micronutrient testing.

17. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

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

   This exclusion does not apply to mammography.

N. Reproduction

1. The following infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials, except as described under *Infertility Services* in *Section 1: Covered Health Care Services*.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services.

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

   - All costs related to reproductive techniques including:
     - Assistive Reproductive Technology (ART).
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).

     The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* in *Section 1: Covered Health Care Services*.

   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. Costs of donor eggs and donor sperm.
4. The reversal of voluntary sterilization.
5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility.

O. Services Provided under another Plan

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

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

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Transplants

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

Q. Travel

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

R. Types of Care

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

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which are determined to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.

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

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:

   - Required only for school, sports or camp, travel, career or employment, insurance, marriage, Civil Union or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.

3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.

5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.

6. Charges in excess of the Allowed Amount or in excess of any specified limitation.

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

8. Autopsy, except as described in *Section 8: General Legal Provisions*.

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

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

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or bacterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, following a Cosmetic Procedure, that require hospitalization.

11. Services for the treatment of Autism Spectrum Disorders provided by or required by law to be provided by a school, municipality or other state or federal agency.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

What If You Are Eligible for Medicare?

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

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

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

If at least one other Enrolled Dependent is covered under the Policy, coverage will be provided for a newborn Dependent from the moment of birth for 31 days, regardless if notification and additional Premium is made. Coverage will continue past the 31 days, if we receive notification and the required Premium.

In the event that there are no other Enrolled Dependents, immediate coverage for the newborn shall be provided if you apply for Dependent coverage within 31 days of the newborn's birth. Such coverage will be contingent upon payment of the additional Premium.

Special Enrollment Period

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

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

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

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

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

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

Coverage will not be discontinued for any Covered Person based on that Covered Person's participation in a Qualified Clinical Cancer Trial.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

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

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Dependent Child with a Disability

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

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

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

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

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

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

Extended Coverage for Total Disability

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

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

Continuation of Coverage and Conversion

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

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

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

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

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

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

General - Continuation of Coverage under State Law

A Covered Person whose coverage under the Policy would otherwise end because of a qualifying event and who was continuously covered under the Policy (or a prior plan for which the Policy replaced) for a period of at least three months ending with termination, shall be entitled to elect continuation of coverage as required by state law, including that of any Enrolled Dependents, as set forth below.

Note: If termination is due to retirement and the Subscriber's spouse is at least 55 years of age, continuation for such spouse will be provided as stated below.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Group for any reason other than commission of a felony or theft related to employment for which the Group was in no way responsible. The Subscriber's admission of guilt, or conviction, or order of supervision by a court of competent jurisdiction, will constitute proof of such act.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Group will provide you with written notification of the right to continuation coverage. If you wish to continue coverage you must request continuation in writing within the 30 day period following the later of:

- The date of such termination or reduction in hours below the minimum required by the Group; or
- The date you are given written notice of the right of continuation by the Group.

In no event, however, may the Covered Person elect continuation more than 60 days after the date of such termination or reduction in hours below the minimum required by the Group. Written notice of continuation presented to the Covered Person by the Group, or mailed by the Group to the last known address of the Covered Person, shall constitute the giving of notice for the purpose of this provision.

Terminating Events for Continuation Coverage under State Law

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

- Twelve months from the date your continuation began.

- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under Medicare or any other group health plan.
- The date the Policy ends.

General - Continuation Coverage After Dissolution of Marriage/Civil Union, Retirement or Death

A Covered Person who is a former spouse or Enrolled Dependent child whose coverage under the Policy would otherwise end because of a qualifying event shall be entitled to elect continuation coverage as required by state law. The term "former spouse" shall include the Subscriber's widow or widower.

Note: A former spouse or Enrolled Dependent child may be entitled to elect either state or federal continuation coverage. Please contact the Group to determine which is applicable.

Qualifying Events for Continuation Coverage After Dissolution of Marriage/Civil Union, Retirement or Death

If the Covered Person's coverage terminated due to one of the following qualifying events, he or she is entitled to continue coverage. The Covered Person may elect the same coverage that he or she had at the time of the following qualifying event:

- Death of Subscriber.
- Legal separation, divorce, annulment of marriage or dissolution of Civil Union from the Subscriber.
- Retirement of the Subscriber.

Notification Requirements and Election Period for Continuation Coverage After Dissolution of Marriage/Civil Union, Retirement or Death

The notification requirements and applicable time periods are as follows:

- The former spouse, Enrolled Dependent child or responsible adult acting on behalf of the Enrolled Dependent child must give written notice to the Group and us within 30 days of the date of the qualifying event.
- The Group must give written notice to us of the qualifying event. This must happen within 15 days after receiving notice, as provided above.
- We, by certified mail, return receipt requested, shall notify the former or retired Subscriber's spouse, Enrolled Dependent child or responsible adult acting on behalf of the Enrolled Dependent child or the Group. Such notice shall include: (a) a form for election of continuation coverage and instructions for returning the election form; (b) the amount of the monthly Premium to be charged; and (c) the manner, place and time, in which the Premium payment must be made; (d) instructions for returning the election form within 30 days after the date it is received from us.

  If the Enrolled Dependent child or responsible adult acting on behalf of the Enrolled Dependent child fail to exercise the election to continue coverage by notifying us in writing within such 30 day period shall terminate the continuation of Benefits and the right to continuation.

If we fail to notify either the Group, Enrolled Dependent child or responsible adult acting on behalf of the Enrolled Dependent child all Premiums shall be waived from the date the notice was required until notice was sent, and the Benefits shall continue under the terms and provisions of the Policy, except if the benefits in existence at the time our notice was to be sent are terminated for all employees.

- A former or retired Subscriber's spouse must elect continuation coverage and pay the first Premium within 30 days after the date of receipt of notice from us. Subsequent Premiums must be paid monthly in advance. If the former spouse is under age 55, the Premium rate shall be the group rate then in effect. If the former or retired Subscriber's spouse is over age 55, the Premium rate shall be the group rate then in effect; however, after two years of continuation coverage, the rate shall be the group rate plus 20% for the cost of administration.

  An Enrolled Dependent child or responsible adult acting on behalf of the Enrolled Dependent child must elect continuation coverage and pay the first Premium within 30 days after the date of receipt of notice from us. All Premiums must be paid in advance. The Premium rate shall be the amount, if any, that would be charged an employee if the Enrolled Dependent child were a current employee and the amount, if any, that the Group would contribute toward the Premium if the Enrolled Dependent child were a current employee. Failure to pay the first Premium within 30 days after the receipt of notice from us as to the Enrolled Dependent child's right to continuation shall terminate the continuation of Benefits and the right to continuation.

Terminating Events for Continuation Coverage After Dissolution of Marriage/Civil Union, Retirement or Death

For a former spouse continuation coverage under the Policy will end on the earliest of the following dates:

- Two years after the date of the qualifying event if the former spouse is under age 55 at the time of the qualifying event.
- The date the former or retired Subscriber's spouse becomes entitled to Medicare benefits.
- The date the former or retired Subscriber's spouse becomes insured under any other group health plan.
- The date the former spouse remarries or enters into a Civil Union.
- The last day of the Policy month for which Premium has been paid.
- The date the Policy, or a class to which the Covered Person belonged, terminates.

For an Enrolled Dependent child continuation coverage under the Policy will end on the earliest of the following dates:

- Failure to pay Premiums when due, including any grace period allowed by the Policy.
- When coverage would terminate under the terms of the existing Policy if the Enrolled Dependent child was still an eligible Dependent of the employee.
- The date on which the Enrolled Dependent child first becomes, after the date of election, an insured employee under any other group health plan.
- The expiration of two years from the date continuation coverage began.

Upon termination of the Policy, as described above, the Enrolled Dependent child shall be entitled to a conversion Policy, if the Enrolled Dependent child elects to convert.

Continuation of Coverage - Dependent Students; Medical Leave of Absence

Continuation of coverage is available for a Dependent college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic Sickness or Injury.

Continued coverage will terminate 12 months after notice of the Sickness or Injury or until the coverage would have otherwise ended under the Policy, whichever comes first.

The need for part-time status or medical leave of absence must be supported by a Physician's clinical certification of need.

Conversion

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

Reasons for termination:

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

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

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Notice of Claim

Written notice of claim must be provided to us within 20 days after the occurrence or commencement of any Covered Health Care Service, or as soon thereafter as reasonably possible.

Required Information

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

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

The above information should be filed with us at the address on your ID card. For additional assistance, a claim form may be obtained from www.myuhc.com.

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

Optum RX

PO Box 29077

Hot Springs, AR 71903

Payment of Benefits

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

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

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

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

Timely Payment of Claims

All claims payable under the terms of the Policy will be paid within 30 days following receipt of proof of loss. If we fail to pay within 30 days, you are entitled to interest at the rate of nine percent per annum from the 30th day.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint or an Appeal?

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

If you would rather send your complaint to us in writing, the representative can provide you with the address. You may also take your matter up with the *Illinois Department of Insurance (DOI)* at the contact information shown below:

Illinois Department of Insurance

Office of Consumer Health Insurance

320 West Washington St.

Springfield, IL 62767

Toll-free Telephone: 877-527-9431

Fax number: 217-558-2083

Email: complaints@ins.state.il.us

Website: https:/mc.insurance.illinois.gov/messagecenter.nsf

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

First Level Review

Step 1:

A written complaint must be submitted to the address below. You, your designee or guardian, your Physician or your health care provider may file the appeal.

Written complaints should be addressed to:

UnitedHealthcare

Appeals Document Request

PO Box 30573

Salt Lake City, UT 84130-0573

Telephone: 866-842-9268

Fax: 801-994-1083

Email (for new submissions only):

Nasc_oldsmar_admin@uhc.com

Step 2:

We will acknowledge, in writing, the receipt of your appeal within three business days and request all the information required to evaluate your case.

Step 3:

A formal decision will be made within 15 business days after receipt of all required information. You will be notified orally of the decision and written notice will be sent following oral notification.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 24 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 orally of the decision within 24 hours following receipt of the required information. Written notice will be sent following oral notification.

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

Administrative Complaints

If you have a complaint concerning products, services, operations or protocols, you should call the telephone number shown on your ID card.

A representative is available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A representative will return your call. If you would rather send your complaint to us in writing at this point, the representative can provide you with the appropriate address.

Exhaustion of Internal Appeal Process

You must first exhaust the internal appeal process before requesting an external review, unless:

- You or your authorized representative have filed an appeal under our internal appeal process and have not received a written decision on the appeal 30 days following the date you or your authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 60 days following the date you or your authorized representative files an appeal of an adverse determination that involves a retrospective review request, except to the extent that you or your authorized representative requested or agreed to a delay;
- You or your authorized representative requested an expedited internal review of an adverse determination but has not received a decision from us within 48 hours after receipt of the information (unless you or your authorized representative agreed to a delay);
- We waive the exhaustion of the internal appeal process requirement;
- You have a medical condition in which the timeframe for completion of:
  - An expedited internal review of an appeal involving an adverse determination;
  - A final adverse determination; or
  - A standard external review would seriously jeopardize your ability to regain maximum function;
- An adverse determination concerns a denial of coverage based on determination that the recommended or requested health care service or treatment is experimental or investigational and your health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. In such cases, you or your authorized representative may request an expedited external review at the same time you or your authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review shall determine whether you are required to complete the expedited review of the appeal prior to conducting the expedited external review;
- The final adverse determination concerns an admission, availability of care, continued stay, or healthcare services for which you received Emergency Health Care Services but have not been discharged from the facility, then you or your authorized representative, may request an expedited external review; or

- We have failed to comply with applicable State and federal law governing internal claims and appeals procedures.

Standard External Review (including Experimental and Investigational Treatment Reviews)

If we have denied your request for the provision of or payment for a health care service or course of treatment, you have the right to have our decision reviewed by an independent review organization not associated with us by submitting a written request for an external review to the *DOI* within four months after the date of receipt of a notice of an adverse or final adverse determination. Additional information may be submitted with the original External Review request.

For more information or to initiate this process, you or your authorized representative can either call or write:

Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield, IL 62767

Toll Free phone number: (877) 850-4740

Fax number: (217) 557-8495

Email address: doi.externalreview@illinois.gov

https://mc.insurance.illinois.gov/messagecenter.nsf

The deadline for filing an external review request are not postponed or delayed by health care provider appeals unless the health care provider is acting as an authorized representative for the Covered Person. The Covered Person should be filing internal appeals independently and concurrently unless the health care provider has been designated in writing as the authorized representative.

Within one business day after the date of receipt of a request for external review, the *DOI* will send a copy of the request to us.

We will complete a preliminary review of the external review request within five business days of receipt to determine whether:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Care Service, but we have determined that they are not covered;
- You have exhausted our internal appeal process unless you are not required to exhaust our internal appeal process;
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician; and
- You have submitted all required information and forms.

Within one business day after completing the preliminary review, we will provide written notice to you and the *DOI* indicating whether the request is complete and eligible for external review. If incomplete, we will notify you and the *DOI* of any missing information needed to complete the request. If ineligible, we will

explain the reasons for ineligibility for external review and notify you and the *DOI* that you may file a complaint regarding our decision to the *DOI*. The *DOI* is authorized to reverse our initial determination and require that the request be referred for external review.

If eligible for external review, within one business day after the date of receipt of the notice, the *DOI* will:

- Randomly assign an independent review organization from the *DOI*'s list of approved independent review organizations qualified to conduct an external review and notify us of the name of the assigned independent review organization; and
- Notify you in writing of the request's eligibility and the name of the assigned independent review organization. The *DOI* must also include in the notice a statement that you may, within five business days of the notice receipt, submit in writing to the assigned independent review organization any additional information to be considered by the independent review organization in the review. (The independent review organization is not required to, but may, accept and consider additional information submitted after five business days).

Within five business days of assigning an approved independent review organization, we will send the independent review organization any documents and information considered in making the adverse determination. If we fail to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify us and you within one business day (immediately for Experimental or Investigational Services).

In addition to any documents and information provided by us and you, an independent review organization shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer. Additionally, for Experimental or Investigational Services the independent review organization shall also consider *FDA*-approval (if applicable) or medical or scientific evidence or evidence-based standards. Within 20 days after being selected to conduct the external review of the Experimental or Investigational Service, each clinical reviewer must provide to the independent review organization a written opinion on whether the services or treatment should be covered.

The independent review organization must provide written notice of its decision to us, you and the *DOI* within five business days after receiving all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review (for Experimental or Investigational Services a written notice must be provided within 20 days after receiving the opinion of each clinical reviewer).

- The independent review organization notice must include a general description of the reason for the external review request, the date it was assigned from the *DOI*, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, the principal reason(s) for its decision, and the rationale for its decision.
- For experimental or investigational treatment reviews, the independent review organization notice must also include descriptions of the factors considered by the independent review organization in making its decision.

Upon receipt of a notice of a decision reversing the adverse or final adverse determination, we will immediately approve the coverage that was the subject of the adverse or final adverse determination.

Expedited External Review (including Experimental and Investigational Treatment Reviews)

You or your authorized representative may request, in writing, an expedited external review with the *DOI*. Additional information may be submitted with the original External Review request:

- After receiving a notice of adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or
  - The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated; an expedited external review may be requested at the same time you or your authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether you are required to complete the expedited review of the appeal prior to conducting the expedited external review.
- After receiving a notice of final adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for a standard external review;
  - The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received Emergency Health Care Services but have not been discharged from the facility, then you or your authorized representative, may request an expedited external review;
  - The final adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated; or
  - We fail to provide a decision on an expedited internal appeal within 48 hours.

Upon receipt of a request for an expedited external review, the *DOI* will immediately send a copy of the request to us.

The request must meet the following reviewability requirements:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Care Service, but we have determined that they are not covered;
- You have exhausted our internal appeal process unless you are not required to exhaust our internal appeal process;
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician; and
- You have submitted all required information and forms.

We will notify you, your authorized representative and the *DOI* of our eligibility determination.

If determined ineligible for expedited external review, we will also notify you that you may file a complaint regarding our decision to the *DOI*.

Upon receipt of the notice that the request meets the reviewability requirements, the *DOI* will:

- Immediately and randomly assign an independent review organization from the *DOI*'s list of approved independent review organization qualified to conduct external review; and
- Immediately notify us of the name of the assigned independent review organization.

We will provide or transmit (electronically, by telephone, facsimile or any other available expeditious method) to the assigned independent review organization all necessary documents and information considered in making the final adverse determination. We will provide this information immediately upon receipt from the *DOI* of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice. If we fail to do so, the independent review organization may terminate the external review and reverse the adverse or final adverse determination in which case the independent review organization must notify us, the *DOI*, and you within one business day.

In addition to any documents and information provided by us and you, an independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the independent review organization's clinical reviewer. Additionally, for Experimental or Investigational Services the independent review organization shall also consider *FDA*-approval (if applicable) or medical or scientific evidence or evidence-based standards. As quickly as possible, but in no event no more than five calendar days after being selected to conduct the external review of the Experimental or Investigational Service, each clinical reviewer must provide to the independent review organization an oral or written opinion on whether the services or treatment should be covered. If the opinion was not in writing, then within 48 hours after providing that opinion, the clinical reviewer must provide written confirmation of the opinion to the independent review organization.

The independent review organization must reach a decision and notify us, the *DOI* and you as quickly as your medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review. For an expedited external review of Experimental or Investigational Services, the independent review organization must make a decision and provide oral or written notice of its decision as expeditiously as the Covered Person's medical condition or circumstances requires, but in no event more than 5 calendar days after being selected to us, the *DOI*, you and your authorized representative. If the notice was not in writing, then within 48 hours after providing that notice, the independent review organization must provide written confirmation of its decision to us, the *DOI*, you and your authorized representative.

The independent review organization is not bound by any decisions or conclusions reached in our utilization review or internal appeal process.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we will immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

If the independent review organization's decision was not in writing, then within 48 hours of rendering its decision, the independent review organization must provide written confirmation of its decision to us, the *DOI* and you. The confirmation must include the following information:

- A general description of the reason for the external review request, the date the independent review organization received the assignment from the *DOI*, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, the principal reason(s) for its decision, and the rationale for its decision.
- For experimental or investigational treatment reviews, descriptions of the factors considered by the independent review organization in making its decision.

Expedited external review is prohibited for retrospective adverse or final adverse determinations.

Independent Review Organization

All decisions by the independent review organization are deemed as binding on us, and on you to the extent that you have other remedies available under applicable federal or state law.

We will approve coverage if the independent review organization reverses the final adverse decision.

Appeals to the Department of Insurance

If your request for a standard external review (or Expedited External Review) is deemed to be ineligible for review by us or our representative, you or your authorized representative may file a complaint with the *Illinois Department of Insurance*. To appeal initial determinations of ineligibility for standard external review (or Expedited External Review) please contact:

To file a Complaint:

Illinois Department of Insurance

Office of Consumer Health Insurance

320 West Washington Street

Springfield, IL 62767

Toll Free phone number: (877) 527-9431

Fax number: (217) 558-2083

Email address: complaints@ins.state.il.us

https://mc.insurance.illinois.gov/messagecenter.nsf

For External Requests and Questions:

Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield, IL 62767

Toll Free phone number: (877) 850-4740

Fax number: (217) 557-8495

Email address: doi.externalreview@illinois.gov

https://mc.insurance.illinois.gov/messagecenter.nsf

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

   1. Plan includes: Individual and group and non-group insurance contracts; uninsured arrangements of individual, group or group-type coverage (whether insured or uninsured); individual and group or group-type coverage through health maintenance organization (HMO) contracts and other prepayment, group practice and individual practice plans; amount by which individual, group or group-type hospital indemnity benefits exceed $100 per day; medical benefits coverage in individual or group automobile contracts, in group or individual automobile "no fault" contracts, and in traditional automobile "fault" type contracts, to the extent those contracts are primary plans; medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, except as provided in this definition. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

   2. Plan does not include: Individual and group or group-type hospital indemnity benefits of $100 per day or less; 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 coverages. These contracts cover elementary and secondary school students and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; A law

or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-government plan; Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; Medicaid policies; A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; and disability income protection coverage.

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

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

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 or party to a Civil Union:

(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.

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

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

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

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member,

subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

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

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

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may 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.

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

Notice

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

Statements by Group or Subscriber

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

Time Limit on Certain Defenses

A Policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

To the extent permitted by law, we have the right, and without your approval, to change, withdraw or add Benefits or end the Policy.

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we, at our own expense, shall have the right and opportunity to examine the Covered Person when and as often as reasonably required during a claims pending period. We may also conduct an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, you retain the right to change that designation of beneficiary or beneficiaries.

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Medicare Eligible?

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

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

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

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

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the Benefits we paid for that Sickness or Injury.

You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Policy to treat your injuries. Under subrogation, the Policy has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

Right of Reimbursement

If a Covered Person recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all Benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise by the Covered Person, Covered Person's parents, if the Covered Person is a minor, or Covered Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- 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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

When Do We Receive Refunds of Overpayments?

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

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

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

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

Prior to bringing any legal action against us to recover reimbursement we recommend that you complete all the steps in the complaint and appeal process described in *Section 6: Questions, Complaints and Appeals*. If you want to bring a legal action against us, you must do so 60 days after written proof of loss has been furnished or within three years of the date we notified you of our final decision, otherwise you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

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

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

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

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

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

It may also provide Mental Health Care Services or Substance Use Disorders Services on an outpatient or inpatient basis.

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

Amino Acid-Based Elemental Formulas - a special liquid type nutritional product made up of amino acids which are the building block of proteins and typically more tolerable.

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

Applied Behavior Analysis (ABA) - the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior. This includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Assisted Reproductive Technology (ART) - treatments and/or procedures in which the human oocytes and/or sperm are retrieved and the human oocytes and/or embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an oocyte retrieval is performed.

Autism Spectrum Disorder - a pervasive developmental disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

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

Breast Tomosynthesis - a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three dimensional images of the breast.

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

Civil Union - a legal relationship between two persons, either the same or opposite sex, established pursuant to the *Illinois Religious Freedom Protection and Civil Union Act*.

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

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

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

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

- The Co-payment.
- The Allowed Amount.

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

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

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

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

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

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

Customized Orthotic Device - a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the replacement or repair of the device based on your physical condition as Medically Necessary, excluding foot orthotics defined as an in-shoe device designed to support the structural components of the foot during weight-bearing activities.

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

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

- A natural child.
- A stepchild.
- A legally adopted child or a child not residing with the insured (foster child). A child in the custody of the insured pursuant to an interim court order of adoption is considered an adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Dependent Child with a Disability*.
- Any unmarried dependent child under 30 if the Dependent:
  - Is an Illinois resident,
  - Served as active or reserve member of any *U.S. Armed Forces*, and
  - Received release or discharge other than dishonorable discharge.

  To be eligible for this, the Dependent must submit to us a form approved by the *Illinois Department of Veterans' Affairs* stating the date on which the dependent was released from service.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26, or no longer has a disabling condition and dependent upon the Subscriber.

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

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

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

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

Designated Provider - a provider and/or facility that:

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

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

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

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

Diagnosis of Autism Spectrum Disorders - one or more tests, evaluations, or assessments to diagnose whether an individual has Autism Spectrum Disorder that is prescribed, performed, or ordered by:

- A Physician licensed to practice medicine in all its branches.
- A licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders.

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

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

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

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

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

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

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

Eosinophilic Disorders - a digestive disorder where eosinophils (a type of white blood cell) are found in above normal amounts in one or more areas of the digestive tract. They can be on the esophagus, stomach, and both large and small intestines and if left untreated may cause poor growth or malnutrition.

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

  Where a drug prescribed for the treatment of a type of cancer has not been approved by the *FDA* for this particular purpose, the Policy will include coverage of such drug, provided:

  - The drug was approved by the *FDA* for the treatment of some kind of cancer; and
  - The drug has been recognized for the treatment of the specific type of cancer for which it was prescribed in any one of the following established reference compendia:
    - The *American Hospital Formulary Service Drug Information*.
    - The *National Comprehensive Cancer Network's Drugs & Biologics Compendium*.
    - The *Thomson Micromedex's DrugDex*.
    - The *Elsevier Gold Standard's Clinical Pharmacology*.
    - Other authoritative compendia as identified by *the Federal Secretary of Health and Human Services*.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

- We may consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:

  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;

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

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

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

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

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

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

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

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

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

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

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

Infertility - the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful Pregnancy. For purposes of this Benefit, a woman shall be considered infertile without having to engage in one year of unprotected sexual intercourse if a Physician determines that:

- A medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or
- Efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful Pregnancy.

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

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

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

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

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

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

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

Intermittent Care - skilled nursing care that is provided either:

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

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

Low-dose Mammography - the x-ray exam of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast. The term also includes digital mammography and Breast Tomosynthesis.

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

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

Medically Necessary - health care services that are all of the following:

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

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from

more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also 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 when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

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

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

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

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

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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

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

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration* (*FDA*) and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.

- December 31st of the following calendar year.

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

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Pain Therapy - therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the Pain Therapy against these goals.

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

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy. If the Policy covers optometry, you have the option to have optometric services reimbursed to either a Physician or optometrist.

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

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

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

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

Preventive Physical Therapy - physical therapy that is prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

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

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

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

Qualified Clinical Cancer Trial - includes the following criteria:

- The effectiveness of the treatment has not been determined relative to established therapies;
- The trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;
- The trial is:
  - Approved by the *FDA*; *or*
  - Approved and funded by:
    - *National Institutes of Health (NIH)*;
    - *The Centers for Disease Control and Prevention (CDC)*;
    - *The Agency for Healthcare Research and Quality (AHRQ)*;
    - *The United States Department of Defense (DOD)*;
    - *The United States Department of Veterans Affairs (VA)*;
    - *The United States Department of Energy* in the form of an investigational new drug application; or
    - A cooperative group or center of any entity described in this listing.
- The patient's Primary Care Physician, if any, is involved in the coordination of care.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance Use Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance Use Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance Use Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

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

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

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

Substance Use Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and*

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

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

Total Disability - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance Use Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Treatment for Autism Spectrum Disorders - includes the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by:

- A Physician licensed to practice medicine in all its branches.
- A certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:
    - Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
    - Psychological care, meaning direct or consultative services provided by a licensed psychologist.
    - Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an individual.
    - Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
        - Self-care and feeding.
        - Pragmatic, receptive, and expressive language.
        - Cognitive functioning.
        - Applied Behavior Analysis, intervention, and modification.
        - Motor planning.
        - Sensory processing.

Treatment Plan - may consist of, but is not limited to, diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals and the frequency by which the Treatment Plan will be updated. Medical records and clinical notes may also be requested.

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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Dental Anesthetic Coverage Amendment

UnitedHealthcare Insurance Company of Illinois

As described in this Amendment, the Policy is modified to provide additional coverage for Dental Anesthetics.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms.*

Section 1: Covered Health Care Services

Dental Services - Anesthesia and Facility in the Certificate, Section 1: Covered Health Care Services is replaced with the following:

Dental Services - Anesthesia and Facility

Services for general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of a dental condition. Services are limited to a Covered Person who:

- Is six years of age and under;
- Has one or more medical conditions that require hospitalization or general anesthesia for dental care; or
- Is a person with a disability.

Services for general anesthesia provided by a dentist who has obtained a permit for the administration of anesthetics under the *Illinois Dental Practice Act*, in conjunction with dental care that is provided to a Covered Person in a dental office, oral surgeon's office, hospital or ambulatory surgical treatment center will be provided if the Covered Person:

- Is under age 26; and
- Has been diagnosed with an Autism Spectrum Disorder or a disability.

Note: A Covered Person must make two visits to the dental care provider before accessing this coverage.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

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Diagnostic Mammography Amendment

UnitedHealthcare Insurance Company of Illinois

As described in this Amendment, the Policy is modified to provide additional Benefits for diagnostic mammograms.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms.*

Section 1: Covered Health Care Services

Diagnostic mammography is added to the Certificate in Section 1: Covered Health Care Services:

Lab, X-Ray and Diagnostic - Outpatient

- Diagnostic mammography, which includes a screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast at no cost share after the deductible is met.

Preventive Care Services

Illinois mandated preventive health care services

- Diagnostic mammography, which includes a screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

Hearing Aids Amendment

UnitedHealthcare Insurance Company of Illinois

As described in this Amendment, the Policy is modified to revise Benefits for hearing aids for Covered Persons.

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*.

The description under the Covered Health Care Service column for Hearing Aids is replaced in the Schedule of Benefit with the following:

Hearing Aids

Benefits are limited to one hearing instrument per hearing impaired ear every 24 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

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Human Breast Milk Amendment

UnitedHealthcare Insurance Company of Illinois

As described in this Amendment, the Policy is modified to provide Benefits for human breast milk.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms.*

Section 1: Covered Health Care Services

The following provision is added to the Certificate, Section 1: Covered Health Care Services:

Human Breast Milk

Benefits include pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed Physician, for:

- Covered Persons under the age of 6 months, when all of the following conditions are met.
  - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.
  - The milk is obtained from a human milk bank that meets quality guidelines established by the *Human Milk Banking Association of North America* or is licensed by the *Department of Public Health*.
  - The infant's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
  - One or more of the following applies:
    - The infant's birth weight is below 1,500 grams.
    - The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
    - The infant has infant hypoglycemia.
    - The infant has congenital heart disease.
    - The infant has had or will have an organ transplant.
    - The infant has sepsis.
    - The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the infant.
- Covered Persons 6 months through 12 months of age, when all of the following conditions are met.
  - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.

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- The milk is obtained from a human milk bank that meets quality guidelines established by the *Human Milk Banking Association of North America* or is licensed by the *Department of Public Health*.
- The child's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated.
- One or more of the following applies:
  - The child has spinal muscular atrophy.
  - The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
  - The child has had or will have an organ transplant.
  - The child has a congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the child.

Benefits

Benefits for Covered Health Care Services related to Human Breast Milk will be the same as those stated under Amino Acid-Based Elemental Formulas within the Schedule of Benefits.

Section 2: Exclusions and Limitations

The exclusion for donor breast milk in the Certificate under Section 2: Exclusions and Limitations, Nutrition is replaced with the following:

2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk. This exclusion does not apply to donated human breast milk for which Benefits are provided as described under *Human Breast Milk* in *Section 1: Covered Health Care Services*.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

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Whole Body Skin Examination Amendment

UnitedHealthcare Insurance Company of Illinois

As described in this Amendment, the Policy is modified to provide Benefits for whole body skin examinations.

Because this Amendment is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms.*

Section 1: Covered Health Care Services

The following service is added to the Certificate under Preventive Care Services, Illinois mandated preventive health care services, in Section 1: Covered Health Care Services:

Preventive Care Services

Illinois mandated preventive health care services

- One annual office visit for a whole body skin examination for lesions suspicious for skin cancer.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

Outpatient Prescription Drug

UnitedHealthcare Insurance Company of Illinois

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products (orally-administered) will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate*, regardless of tier placement.

Refill Synchronization

On behalf of Illinois state law, we will provide synchronization of prescription drug refills, on at least one occasion per insured per year, provided all of the following conditions are met:

- The prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process.
- The drugs are maintenance medications as defined by the plan and have all available refill quantities at the time of synchronization.
- The medications are not Schedule II, III, or IV controlled substances.
- The insured meets all utilization management criteria to the drugs at the time of synchronization.
- The drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization.
- The drugs do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription.
- The covered person agrees to synchronization.

When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to the above requirements.

You may access additional information on refill synchronization by contacting us at www.myuhc.com or the telephone number on your ID card.

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits or dose restrictions based on criteria that we have developed and subject to prior authorization. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network

Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after review of the documentation provided determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card. Prior authorization coverage criteria for step therapy is also located on www.uhcprovider.com.

You may have the right to request an exception. Refer to *Section 4: Your Right to Request an Exclusion Exception* in the *Outpatient Prescription Drug Rider* for additional information.

In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature.

What Do You Pay?

We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

Payment Term And Description	Amounts
number on your ID card. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an	

Payment Term And Description	Amounts
affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the *Smart Fill Program*. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $35.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $60.00 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $35.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $60.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply:	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
• As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. You may also receive up to a 12-month cycle of the same contraceptive for subsequent dispensing at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied, when the prescriber writes the prescription to fill a 12-month supply. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.	Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $35.00 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $60.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $35.00 per

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
insurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.	Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $60.00 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a 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 *Specialty Prescription Drug Products*. You may also receive up to a 12-month cycle of the same contraceptive for subsequent dispensing at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied, when the prescriber writes the prescription to fill a 12-month supply. We may allow a 31-day fill at the mail order Network Pharmacy for certain Prescription Drug Products for the Co-payment and/or Co-insurance you would pay at a retail Network Pharmacy.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $25.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $87.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $150.00 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
You may find out whether a 31-day fill of Prescription Drug Product is available through the mail order Pharmacy for a retail Network Pharmacy Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company of Illinois

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate*.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year and notice will be provided at least 60 days prior to this change.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

Smart Fill Program - Split Fill

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

Smart Fill Program - 90-Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90-day supply of certain Specialty Prescription Drug Products if you are 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*, by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. We may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can

determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

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 taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Breast Cancer Pain Medication

Benefits are provided for all Medically Necessary pain medication related to the treatment of breast cancer.

Immunosuppressant Drugs

Immunosuppressant drugs are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system as well as used to prevent the rejection of transplanted organs and tissues. When the prescribing Physician has indicated on the prescription "may not substitute," we will not require or cause a pharmacist to interchange another immunosuppressant drug or formulation unless we receive documented consent. Consent would be required of the prescribing Physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the person. Except for a change in the formulary as described below, Co-payments, deductibles, or other charges for the prescribed drug for which another immunosuppressant drug or formulation is not interchanged will remain the same for the remainder of the calendar year.

At least 60 days before we make any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or if we discontinue coverage for a prescribed immunosuppressant drug that a patient is receiving, we will, to the extent possible, notify the prescribing Physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change. It will indicate that the prescribing Physician may initiate an appeal, and will include information regarding the Policy's appeal process.

Opioid Antagonists

Refer to the Prescription Drug List for covered Opioid Antagonists. Covered expenses include the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the Opioid Antagonist. Coverage includes refills for expired or utilized Opioid Antagonists included on the Prescription Drug List.

Topical Eye Medications

Benefits for the early refill of a prescription for topical eye medication are available when:

- The medication is to treat a chronic condition of the eye;
- The refill is requested by the insurer prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use;
- The prescribing Physician licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested do not exceed the total number of refills prescribed.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

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

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

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 contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained.

3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined to be experimental, investigational or unproven. This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of a type of cancer for which the Prescription Drug Product has not yet been approved by the *U.S. Food and Drug Administration (FDA)* if the Prescription Drug Product is recognized for the specific treatment for which it was prescribed in a recognized peer-review medical publication or in one of the following established reference compendia: a) the *American Hospital Formulary Service Drug Information*; b) *National Comprehensive Cancer Network's Drugs & Biologics Compendium*; c) *Thompson Micromedex's DrugDex;* d) *Elsevier Gold Standard's Clinical Pharmacology*; e) other authoritative compendia as identified by the *Federal Secretary of Health and Human Services* or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

8. Any product dispensed for the purpose of appetite suppression or weight loss.

9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. 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. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
12. 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 Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Treatment for toenail Onychomycosis (toenail fungus).
18. Certain Prescription Drug Products for tobacco cessation.
19. Prescription Drug Products not placed on Tier 1, Tier 2 or Tier 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
20. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
21. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter *FDA*-approved contraceptive drugs, devices, and products, excluding male condoms, as provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in the *Certificate*. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
22. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
23. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Amino Acid-Based Elemental Formulas, as described in *Section 1:*

Covered Health Care Services of the *Certificate*, for the treatment of Eosinophilic Disorders and short bowel syndrome as prescribed by a Physician.

25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. 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. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

28. Certain Prescription Drug Products that have not been prescribed by a Specialist.

29. A Prescription Drug Product that contains marijuana, including medical marijuana.

30. Dental products, including but not limited to prescription fluoride topicals, except as required by law.

31. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

32. Diagnostic kits and products.

33. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

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

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

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

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

Infertility - the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful Pregnancy. For purposes of this Benefit, a woman shall be considered infertile without having to engage in one year of unprotected sexual intercourse if a Physician determines that:

- A medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or
- Efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful Pregnancy.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Opioid Antagonist - a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the *FDA*.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* including:
    - Preeclampsia prevention: low-dose aspirin used after 12 weeks of gestation in women who are at high risk for preeclampsia.
    - Dental cavities prevention for children starting at age six months where primary care clinicians prescribe oral fluoride supplementation for those whose water supply is fluoride deficient.
    - Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
    - Certain statin preventive medications for adults ages 40-75 years with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
- 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*.
- *FDA*-approved contraceptive drugs, devices, and other products, including *FDA*-approved contraceptive drugs, devices, and products available over-the-counter, excluding male condoms.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change. You may find

out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - glucagon emergency kits;
  - *FDA*-approved oral agents used to control blood sugar; and
  - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *Certificate*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Synchronization - the coordination of medication refills for a Covered Person taking two or more medications for one or more chronic conditions that are refilled on the same schedule for a given time period.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Section 4: Your Right to Request an Exclusion Exception

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

Urgent Requests

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

External Exception Request Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external exception request review. You or your representative may request an external exception request 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 Exception Request 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 exception request 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.

Real Appeal Rider

UnitedHealthcare Insurance Company of Illinois

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company of Illinois

William J Golden, President

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available 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, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices 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)* to be grandfathered a plan must have been in effect on March 23, 2010 and had no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time (among other requirements).

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 care and substance-related and addictive disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and long term 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 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 health benefits for plan years beginning on or after January 1, 2014, 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. As of September 23, 2010, if you have a grandfathered plan the 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). For plan years beginning January 1, 2014 and beyond, Grandfathered plans are required to cover dependents up to age 26, regardless of their eligibility for other employer sponsored coverage.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the 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, network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, Co-insurance or Co-payment. 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, Co-insurance or Co-payment, 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 (Co-payments/Co-insurance) will be the same as would be applied to care received from 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 persons 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 first 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 take place 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 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 first 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 first 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. Call 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 call 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 Care or Substance-Related and Addictive Disorder Services, the following applies:

Mental Health Care/Substance-Related and Addictive Disorder Services 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 Care Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Care Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Co-insurance and Co-payments for mental health and substance-related and addictive disorder conditions must be no more restrictive than those Co-insurance and Co-payment 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-related and addictive disorder benefits. Based upon the results of that testing, it is possible that Co-insurance or Co-payments that apply to mental health conditions and substance-related and addictive 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 care conditions and substance-related and addictive disorder conditions that are Covered Health Care 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 care conditions and substance-related and addictive disorder conditions that are Covered Health Care Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Care Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for Co-insurance and Co-payments for mental health care and substance-related and addictive disorder conditions must be no more restrictive than those Co-insurance and Co-payment 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 care and substance-related and addictive disorder benefits. Based upon the results of that testing, it is possible that Co-insurance or Co-payments that apply to mental health care conditions and substance-related and addictive 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 Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

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 according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

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

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will be take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

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

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com or www.oxfordhealth.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We 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.
- 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 needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes**. We may 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 review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may 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 needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you,

selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com or www.oxfordhealth.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 call us at 1-866-633-2446 or TTY 711.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

[2]*This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; 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.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Management Corporation; Rocky Mountain HealthCare Options, 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.*

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.;*

LifePrint East, Inc.; LifePrint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health LLC, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.