



Using your pharmacy benefits

Optum Rx® is your plan's pharmacy services manager and is committed to helping you find cost-effective ways to get your medications.

Set up your online account

Once registered on myuhc.com®, access the pharmacy section to:

- Manage your home delivery medications
- Set up email or text message¹ reminders
- Check your home delivery status

Use the UnitedHealthcare app

Manage your prescription benefit and home delivery orders with the UnitedHealthcare® app on your smartphone or tablet.

Use a network pharmacy

Be sure to fill your prescriptions at a network pharmacy, otherwise they may not be covered or you may pay more.² Finding a network pharmacy is easy:

- Log in to myuhc.com
- Or use the UnitedHealthcare app
- Or call the number on your health plan ID card

**United
Healthcare**

Home delivery from Optum

Consider using Optum® Home Delivery to help manage the medications you take regularly. Home delivery is reliable and offers the following advantages:



Cost savings

You may pay less for your medication with a 3-month supply.



Convenience

Get free standard shipping.



24/7 access and reminders

Speak to a pharmacist any time, any day. Set up medication reminders.

You may be able to refill your home delivery prescriptions automatically through the Automatic Refill program.

If you need your medication right away, ask your doctor for a 1-month prescription to fill at a local pharmacy and a 3-month prescription you can use to set up home delivery.

How to choose home delivery

By going online:

Visit myuhc.com, register and follow the simple step-by-step instructions.

By phone:

Call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available.

By ePrescribe:

Your doctor can send an electronic prescription to OptumRx. Prescriptions for controlled substances, such as opioids, can only be ordered by ePrescribe.*

*This update does not apply to providers in Alaska, Guam, Puerto Rico or the U.S. Virgin Islands.

Making medication decisions

Use the UnitedHealthcare prescription drug list (PDL)

The PDL is a list of your plan’s covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

Cost tier	Includes	Helpful tips
\$ Tier 1 — Lowest cost	Lower-cost medications. Some brand-name medications.	In most cases, Tier 1 medications have the lowest cost. Consider generic options which may also help you save.
\$ Tier 2 — Mid-range cost	Mix of brand-name and generic medications.	Tier 2 drugs may cost less than Tier 3 drugs. ³
\$ Tier 3 — Highest cost	Highest-cost brand-name medications and some generic medications.	Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you. ³

*Some Connecticut plans have a 4th tier that includes higher cost brand-name and generic medications, as well as non-preferred brand-name and specialty medications.

Save money

In most cases, generic medications have a lower copay than brand-name medications. Ask your doctor if there is a generic alternative for you.

Compare prices

Search for lower-cost alternatives. Just log in to myuhc.com. Or use the UnitedHealthcare app.



Tips



Know your plan

Your plan may require one or more of the following for your prescription to be covered:

Prior authorization: approval to get a medication.

Step therapy (First Start for NJ plans only): trying one medication before another.

Quantity limits: only a certain amount of the medication is allowed for coverage.

Log on to **myuhc.com** to see if you could save. Or use the UnitedHealthcare app.



Talk to your doctor

When you talk with your doctor, use the UnitedHealthcare app to confirm coverage and costs. You can also talk about what you need to do to get your medication.



Optum Specialty Pharmacy

At Optum® Specialty Pharmacy, we offer the resources, programs and clinical support you need to manage your specialty medications with confidence.

Your plan may also include

Your plan **may include** the cost-saving medication home delivery program below. With each of these programs, you are allowed a limited number of refills at your current pharmacy. Then you must take action.

Mail Service Saver

Switch to Optum Home Delivery or you may pay more.

Mail Service Saver Plus

Switch to Optum Home Delivery or you will pay the full price for your medication.

Nondiscrimination notice and access to communication services

UnitedHealthcare® does not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: **Civil Rights Coordinator.**

UnitedHealthcare Civil Rights Grievance.

P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, **TTY 711**, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free **1-800-368-1019, 800-537-7697 (TDD)**

Mail: **U.S. Dept. of Health and Human Services.**

200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card **TTY 711**, Monday through Friday, 8 a.m. to 8 p.m.

Multi-language interpreter services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, नशिल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ផ្សារព័ត៌មានសេវា: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សម្រាប់ការសម្របសម្រួលសេវាភាសាខ្មែរ គឺមានសេវាឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដើម្បីទទួលបានលេខសេវាឥតគិតថ្លៃបន្ថែម។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguah nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

Díí BAA'ÁKONÍZÍN: **Diné (Navajo)** bizaad bee yániit'ígo, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'í. T'áá shóq'dí ninaaltsoos nít'ízi bee nééhozinígíí bine'déq' t'áá jík'ehgo béesh bee hane'í biká'ígíí bee hodílinih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.



Questions? Visit myuhc.com to learn more.

United Healthcare

¹ Optum Rx provides this service at no cost. Standard message and data rates charged by your carrier may apply.

² In New York, prescriptions filled at an out-of-network pharmacy may not be covered. In New Jersey, you may need to pay more for prescriptions filled at an out-of-network pharmacy.

³ For New Jersey plans, generic drugs will not exceed \$25 for a 30-day supply, preferred drugs will not exceed \$50 for a 30-day supply, and non-preferred drugs will not exceed \$75 for a 30-day supply.

Optum Home Delivery is a service of OptumRx.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health plan coverage provided by or through a UnitedHealthcare company. Optum Rx, Inc. is an affiliate of UnitedHealthcare Insurance Company.

Optum Rx and Optum Specialty Pharmacy are subsidiaries of UnitedHealth Group. UnitedHealthcare and the dimensional U logo are trademarks of UnitedHealth Group Incorporated. All other trademarks are the property of their respective owners.

© 2022 United HealthCare Services, Inc. All Rights Reserved. WF7149599_FI_042022



Important things to know about selecting your PCP

A primary care provider (PCP) is your health guide—someone who can help coordinate your care and supports you in achieving your best health.

Your PCP:

- Must be a general practice, family practice, pediatrician or internal medicine provider*
- Must be an individual provider, not a medical practice**
- Must be accepting new patients (if you are not a current patient)
- Must be located in a town or city near where you (the subscriber) live or work
- Can be selected for the entire family or each covered member can select their own



A PCP is the doctor who knows you best—who understands your health history and health goals. They're who you turn to first—for everything from routine care to prescriptions and more.

And, since most PCPs offer virtual visits for primary care, you can choose to see them in person or from home.

So, whether or not your plan requires you to have a PCP, it's a good idea to choose one.

See reverse side for instructions on how to select a PCP.

*Some states allow you to choose a specialist, like an OB/GYN, as your PCP. Contact your employer for more information.

**Some health plans may allow you to choose a medical group rather than a doctor as your PCP.

continued

Follow these steps to choose your PCP

- 1 • Go to myuhc.com® (you don't need to sign in)
• Then select **Find a Provider > Medical Directory** then, **Employer and Individual Plans**.

Not sure which plan name to look for? Check your open enrollment materials or ask your employer.

- 2 If prompted, select the year in which you will be receiving care (choose the following year if you are making open enrollment selections)—confirm the ZIP code for your search, choose **People**, then **Primary Care**, then select from any of the categories listed.

John Smith, MD
Family Practice
★★★★★ (27)
In-Network

Save (555) 555-1234

OVERVIEW SERVICES & COSTS LOCATIONS PATIENT REVIEWS

2 Locations for 12345

ADJUST RADIUS
Within 20 Miles

Location	Phone	Availability	Additional Information
1234 Main Street, Ste 123 Anytown, ST 12345 4 Miles Away Get Directions View Hours > OPEN NOW	(555) 555-1234 Phone 123 TTY Website Not Available Email Not Available	Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years	Premium Care Physician Accepting All Patients Provider ID 01234567891234 Copy
1010 North Hwy, Ste 100 Othertown, ST 12345 7 Miles Away Get Directions View Hours > OPEN NOW	(555) 555-5555 Phone 456 TTY Website Not Available Email Not Available	Evening Appointments Weekend Appointments Accessibility Parking > Patient Age & Gender Requirements 0 - 150 years	Premium Care Physician Accepting All Patients Provider ID 43219876543210 Copy

- 3 Scroll through the search results, and once you have made your selection, click on the provider's name to **locate the Provider ID in the lower right corner of the page**. Select **Copy** or write it down—you'll need it when you enroll.

- 4 If your selected PCP is associated with multiple locations, you can find the correct Provider ID by selecting **Locations** and then copying the appropriate Provider ID.

And there you have it—choosing your PCP is the first step in the process to help manage your health. Be sure to schedule your first visit with your PCP. It can be a great way for your doctor to get to know you—and vice versa.

Questions?

For enrollment support please call **1-866-873-3903** or visit www.myuhc.com

United Healthcare

This Guide is intended for individuals selecting a new plan (or) in open enrollment. Active members should log in to myuhc.com for assistance.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

UnitedHealthcare Level Funded: Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Stop Loss only: Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company of New York (in NY) and UnitedHealthcare Insurance Company (in all other states and DC).

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

B2C EI232089172.0 3/23 © 2023 United HealthCare Services, Inc. All Rights Reserved. 23-2083880-B

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.



UnitedHealthcare of Washington, Inc.

UnitedHealthcare Choice Plus

**Certificate of Coverage, Riders, Amendments, and
Notices**

for

WTIA Tech 80 | \$1500

Health Plan: EC3N

Prescription Code: J98

Effective Date: December 1, 2024

Offered and Underwritten by UnitedHealthcare of Washington, Inc.

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

UnitedHealthcare Choice Plus

Certificate of Coverage

UnitedHealthcare of Washington, Inc.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare of Washington, Inc. 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.

The *Certificate of Coverage* will prevail over any conflicting terms of the Policy.

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

Can This Certificate Change?

As permitted by law, if there are changes in federal or state laws, we may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

Other Information You Should Have

As permitted by law, if there are changes in federal or state laws, we may change, withdraw or add Benefits, or end the Policy, 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 Washington. The Policy is subject to the laws of the state of Washington and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Washington 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 of Washington, Inc. 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 or access www.myuhc.com. Throughout the document you will find statements that encourage you to contact us for more information. You may also contact us for written or plan specific information including, but not limited to:

- Clinical policies.
- Reimbursement policies.
- Documents, records and other relevant information related to any claim of Benefits.
- Written information on other health plans offered by UnitedHealthcare of Washington, Inc.
- Duplicate ID cards.
- Plan documents, including the *Certificate of Coverage*, *Schedule of Benefits*, *Summary of Benefits and Coverage*.
- The following are health care benefit managers applicable to this plan. This list can also be accessed at www.myuhc.com.
 - Evicore.
 - United Behavioral Health.
 - OptumHealth Care Solutions, LLC.
 - Optum RX, Inc.
 - OrthoNet LLC.
 - Dental Benefit Providers, Inc.

- Spectera.
- UnitedHealthcare Services.

Your Responsibilities

Eligibility, Enrollment, and Required Contributions

Benefits are available to you once you are enrolled for coverage under the Policy. The Group will apply the eligibility rules.

- 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 rules of the Policy issued to your Group, including the eligibility rules.
 - You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Subscriber or Dependent as defined in *Section 9: Defined Terms* and meet the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*.
- Your Benefits are no longer available as described in *Section 4: When Coverage Ends*.

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

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

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. For Network Benefits, you are not responsible for any difference between the Allowed Amount and the amount the provider bills. 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 Allowed Amount. Please refer to *Section 9: Defined Terms* for the definition of 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*.

Our Responsibilities

Determine Benefits

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

We will do the following:

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines, generally 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 (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Offer Health Education Services to You

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

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services	11
Section 2: Exclusions and Limitations	35
Section 3: When Coverage Begins	48
Section 4: When Coverage Ends	52
Section 5: How to File a Claim	56
Section 6: Questions, Complaints and Appeals	58
Section 7: Coordination of Benefits	63
Section 8: General Legal Provisions	70
Section 9: Defined Terms	78
Section 10: Consolidated Appropriations Act Summary	91

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this *Certificate* and the *Group Application*.
- You must see a Choice Network Physician in order to receive Network Benefits. You can confirm that your provider is a Choice Network provider by contacting us at the telephone number on your ID card or you can access a directory of providers online at www.myuhc.com. Please refer to the *Schedule of Benefits* for more information regarding how to access Benefits from a Choice Network provider.

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 or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Acupuncture Services

Acupuncture services provided in an office setting, for the treatment of a Sickness or Injury, including treatment for chemical dependency as described under *Section 1: Covered Health Care Services, Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services*.

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

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

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

2. Ambulance Services

Emergency 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, including services, as described in this section, under *Emergency Health Care Services - Outpatient*. Benefits include, but are not limited to, ambulance or ambulance transport services provided through the "911" emergency response system.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, if determined to be 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.

3. 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*.

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

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from 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, or when you are referred to the clinical trial by a Network provider.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services, such as prescription medications, 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.
- The Experimental or Investigational Service(s) or items that are:
 - Certain *Category B* devices as defined under the *Centers for Medicare and Medicaid Services* guidelines for clinical trials.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or items not described above.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

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

With respect to cardiovascular disease and 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.

5. 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.

6. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage or when the service is emergent in nature.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Please note that dental damage that happens as a result of normal activities of daily living, such as chewing or biting, 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 must be incurred 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.

7. Diabetes Services

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

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

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

Diabetic Self-Management Items

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

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

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

Orthotics

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*.

9. Emergency Health Care Services - Outpatient

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

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

Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.

10. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician. Examples include: nonprescription formulas and special food products that are part of a diet for the treatment of metabolic diseases such as phenylketonuria (PKU).

11. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

12. Gender Dysphoria

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

Coverage is available for medical, behavioral or pharmacological treatment that is Medically Necessary for Gender Dysphoria. UnitedHealthcare does not exclude or deny Covered Health Care Services for Benefits based on an associated diagnosis of Gender Dysphoria, or otherwise discriminate against the Covered Person on the basis that treatment is for Gender Dysphoria. For a list of covered services and any age restrictions, please see the Gender Dysphoria Treatment Medical Policy at the following link: <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/signaturevalue-bip/gender-dysphoria-gender-identity-disorder-treatment-wa.pdf>. You may also contact us at www.myuhc.com or by calling the telephone number on your ID card, if you have any questions or need to determine whether a service is eligible for coverage for gender dysphoria treatment.

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*.

13. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services and health care devices that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age or services to help with keeping or learning skills and functioning within an individual's environment. 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 may include, but are not limited to:

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

Benefits also include habilitative health care devices which require *FDA* approval and a prescription to dispense the device.

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 including, but not limited to any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.

- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

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

We may require the following be provided:

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

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

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

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

14. Hearing Aids

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

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and the initial assessment, testing, fitting, adjustment, auditory training, and ear molds as necessary to maintain optimal fit.

Benefits are also provided for certain *U.S. Food and Drug Administration (FDA)* approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

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

- A medical exam.
- A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

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

hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

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

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

Benefits are available for:

- Prescription drugs and insulin.
- Durable medical equipment as described under *Durable Medical Equipment (DME) Orthotics and Supplies*.
- Supplies normally used during an Inpatient Stay in a Hospital, and dispensed by the Home Health Agency, including, oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions, and intravenous fluids.

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

Please note that if services for palliative care are required in conjunction with treatment or management of serious life-threatening illness, you need not be homebound in order to be eligible for coverage under this section.

16. Hospice Care

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

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.
- Durable Medical Equipment (DME) and supplies that are provided under the hospice care plan.
- Short-term inpatient care for the terminally ill person.

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.

Benefits for hospice care will be provided to you for an initial period of care of not less than six months. Benefits may be provided for an additional six months of care in cases when you are facing imminent death or are entering remission if certified in writing by the attending Physician.

Please note that if services for palliative care are required in conjunction with treatment or management of serious life-threatening illness, you need not be homebound in order to be eligible for coverage under this section.

17. 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.
- 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*.)
- Enteral feedings.

Alternative Care in Lieu of Hospitalization or Institutionalization

Services provided as alternative care in lieu of hospitalization or institutionalization may include Covered Health Care Services furnished by home health, hospice, and home care agencies that are not primarily for the convenience of the patient, Physician, or other health care provider, and are not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Sickness, Injury or disease, including Mental Illness and substance-related and addictive disorders.

Such alternative care coverage in lieu of hospitalization or institutionalization may include Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* under *Durable Medical Equipment (DME), Orthotics and Supplies, Home Health Care, Hospice Care, Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services*. Prior Authorization is required for services provided as alternative care in lieu of hospitalization or institutionalization.

We will work cooperatively with you and your Physician to consider effective alternatives to hospitalization or institutionalization and other high-cost care to make more efficient use of this plan's Benefits. The decision to provide Benefits for these alternatives will be made in accordance with the terms, conditions, exclusions, and limitations of the Policy. Substitution of less expensive or less intensive services shall be made only with the consent of you and your Physician that such services will adequately meet your needs.

We may require that home health agencies or similar alternative care providers have written treatment plans which are approved by your Physician or other licensed health care provider. You may utilize your Benefits as specified in the written treatment plan, but the agreements are not to be construed as a waiver of our right to administer the Benefits in strict accordance with the Policy in all other situations. All parties have the right to re-evaluate or end the written treatment plan at any time.

18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography, as recommended by your Physician. Coverage for supplemental breast examinations and diagnostic breast examinations are described under *Preventive Care Services*.
- Screening for the detection of:
 - Pelvic cancer.

- Colorectal cancer exams and lab tests, as recommended by a Network provider, or out-of-Network provider when a Network provider is not available, for:
 - ♦ Covered Persons at least fifty years of age and older, and
 - ♦ Covered Persons under fifty years of age when high-risk.
- Prostate cancer.
- Osteoporosis.

Benefits include:

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

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

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

19. 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, Alternate Facility, or in a Physician's office.

Benefits include:

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

20. Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services

Mental Health Care and Chemical Dependency/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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure. Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorder Services in a home setting, will be covered under the same terms and conditions applied to inpatient or outpatient Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorder Services under the Policy.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.

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

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

- Eating disorder treatment only when associated with a diagnosis classified in the current edition of *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Prescription medication during the Inpatient Stay in a Hospital or an Alternate Facility.
- Medically Necessary services for parent-child relational problems for children five years or younger; neglect of abuse of a child five years of age or under; bereavement of a child five years of age or under; and gender dysphoria consistent with federal law.
- Behavioral treatment provided for a diagnosis of a condition classified in the current edition of *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Unlimited acupuncture treatments for the treatment of Chemical Dependency.
- Chemical Dependency detoxification.

Benefits under this section include services for Chemical Dependency provided on an outpatient or inpatient basis. Benefits include detoxification which is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Benefits are provided for treatment for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is considered an Emergency when provided in a licensed Hospital.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care at the telephone number located on the back of your ID card.

21. 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.

22. 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, including orally administered anti-cancer medication used to kill or slow the growth of cancerous cells. If the Policy includes an *Outpatient Prescription Drug Rider*, Benefits for orally administered anti-cancer medication will be provided under the prescription drug Benefit.

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 Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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

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.

23. 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.

24. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness, including Mental Illness and substance-related and addictive disorders, 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.

Benefits under this section include:

- Allergy injections and associated supplies and services.
- After the initial 30-day supply, a 12-month refill, may be obtained on one date by the Subscriber, of an *FDA* approved contraceptive drug, unless the Subscriber requests a smaller supply, or the prescribing provider instructs that the Subscriber must receive a smaller supply. We may limit refills obtained in the last quarter of a plan year if a 12-month supply of the contraceptive drug has already been dispensed during the plan year. We may request that you provide proof that the 12-month prescription is a refill if you were covered by a different plan or carrier in the prior plan year. You may be responsible for a Co-payment and/or Co-insurance for each cycle provided. **PLEASE NOTE:** A Co-Payment and/or Co-insurance will not apply to contraceptives covered under PPACA Zero Cost Share Preventive Medications, as defined under the *Outpatient Prescription Drug Rider*, which are payable at 100% of the Prescription Drug Charge.

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

25. 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.

Benefits for Pregnancy also include genetic testing and counseling as part of an amniocentesis or chorionic villus sampling procedure when determined to be Medically Necessary according to the standards set forth by the *Washington Board of Health* for treatment of a heritable disease.

Benefits for Pregnancy include Covered Health Care Services provided in a hospital or at an alternative birthing center, including a home birth. Covered Health Care Services include those provided by a licensed/certified midwife. Covered Health Care Services for prenatal care includes testing which meets the criteria of the *American College of Obstetrics and Gynecology*.

The mother and attending provider will determine the length of hospital stay, however, 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.

If the mother and newborn are discharged earlier than these minimum time frames, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician. The length of stay in connection with the childbirth for the mother shall be determined by the attending provider and the mother based upon accepted medical practice.

Benefits for Medically Necessary donor human milk for inpatient use when ordered by a licensed health care provider or international board-certified lactation consultant for an infant who is medically or physically unable to receive human milk or participate in chest feeding, or whose parent is medically or physically unable to produce milk in sufficient quantities or calories density or participate in chest feeding, if the infant meets at least one of the following:

- An infant birth weight of below 2,500 grams.
- An infant gestational age equal to or less than 34 weeks.
- Infant hypoglycemia.
- A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity.
- A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications.
- Congenital heart disease requiring surgery in the first year of life.
- An organ or bone marrow transplant.
- Sepsis.
- Congenital hypotonias associated with feeding difficulty or malabsorption.
- Renal disease requiring dialysis in the first year of life.
- Craniofacial anomalies.
- An immunologic deficiency.
- Neonatal abstinence syndrome.
- Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived products is medically necessary and supports the treatment and recovery of the child; or
- Any baby still inpatient within 72 hours of birth without sufficient human milk available.

For purposes of this benefit:

"Donor human milk" means human milk that has been contributed to a milk bank by one or more donors.

"Milk bank" means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

26. Preimplantation Genetic Testing (PGT) and Related Services

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

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

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

27. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including colorectal cancer screening, as recommended by a Network provider, or out-of-Network provider when a Network provider is not available, and depression screening for adults, including pregnant and postpartum women, obesity screening for adults and children age 6 years and over, and intensive, multicomponent behavioral interventions for children and adults with a body mass index (BMI) of 30 kg/m² or higher.

Coverage also includes at least one FDA-approved pre-exposure prophylaxis (PrEP) preventive medication for the prevention of HIV infection for people at high risk of infection. PrEP Benefits include:

- Kidney function testing (creatinine).
- Serologic testing for hepatitis B and C virus.
- Sexually transmitted infection screening and counseling.
- Pregnancy testing when appropriate.
- HIV testing.
- 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*, including lactation support and counseling, breast cancer screening/mammogram, cervical and other pelvic cancer screening and osteoporosis screening.

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

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of a rental for hospital-grade pumps).
- Timing of purchase or rental.

Washington mandated preventive health care services

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

- Contraceptive drugs, devices, and other products approved by the *FDA*, including over-the-counter contraceptive drugs devices, and products approved by the *FDA* (including spermicide and condoms for both males and females).
- Voluntary sterilization procedures.

- The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services described above.

Note: Contraceptive medications which you obtain from a pharmacy are covered under the *Outpatient Prescription Drug Rider*.

- With respect to men, additional screening and diagnosis of prostate cancer.
- Supplemental breast examinations and diagnostic breast examinations. For purposes of this benefit:

"Diagnostic breast examination" means Medically Necessary and appropriate examination of the breast, including an examination using diagnostic mammography, digital breast tomosynthesis, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality:

- Seen or suspected from a screening examination for breast cancer; or
- Detected by another means of examination.

"Supplemental breast examination" means a Medically Necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.

Please contact us at www.myuhc.com or by calling the telephone number on your ID card, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

28. Prosthetic Devices

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

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

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

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

The prosthetic device must be 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*.

29. 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.

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

30. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

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

Rehabilitation services must be performed by, including but not limited to, a Physician or by a licensed therapy provider practicing within the scope of their license. 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 for braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts are covered. Benefits also include Durable Medical Equipment (DME), including state sales tax, provided to you by a Physician, as described under *Durable Medical Equipment (DME), Orthotics and Supplies*, above.

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

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

Benefits are not available for maintenance/preventive treatment.

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

Benefits under this section do not include neurodevelopment therapy for Covered Persons as described below under *Additional Benefits Required by Washington Law, Neurodevelopment Therapy*.

31. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

32. 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.
- 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.

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

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

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

33. Surgery - Outpatient

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

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

- Arthroscopy.

- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

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

Benefits include:

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

34. Temporomandibular Joint (TMJ) Services

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

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

Non-surgical treatment including:

- Clinical exams.
- 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.

35. Therapeutic Treatments - Outpatient

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

36. 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.

37. 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*.

38. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

39. Virtual Care Services

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

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

Benefits are available for the following:

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

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

Benefits do not include email or fax, or for services that occur within medical facilities (CMS defined originating facilities).

Additional Benefits Required By Washington Law

40. Abortion of a Pregnancy

Benefits include abortion of a pregnancy including the consultations, examinations, procedures, and necessary medical services received on an Outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

41. Dental Services - Hospitalization and Anesthesia

Benefits for anesthesia and associated facility charges in connection with dental procedures for oral surgery provided in a Hospital or Alternate Facility when your clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or outpatient surgery center setting. Benefits are available for and include but are not limited to the following:

- Children under seven years of age.
- Covered Persons who are developmentally disabled, regardless of age.

42. Neurodevelopment Therapy

Neurodevelopment therapies are services provided to Covered Persons who have developmental delay and are Medically Necessary as determined by your Physician. Services also include Medically

Necessary neurodevelopmental therapy when associated with a diagnosis classified in the current edition of *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Benefits provided will cover the services of those authorized to deliver occupational therapy, speech therapy and physical therapy. Benefits will be payable to restore and improve function, and for the maintenance of a condition where significant deterioration in the child's condition would result without the service.

Benefits are not available for inpatient or residential neurodevelopmental programs in the absence of a medical condition requiring acute medical care.

43. Sexual Assault Services

Coverage is provided to a Covered Person for the screening and Medically Necessary services and prescription medications for the treatment of physical, mental, sexual and reproductive health care needs that arise from a sexual assault. Note: Prescription medications which you obtain from a pharmacy are covered under the *Outpatient Prescription Drug Rider*.

44. Telemedicine

Coverage is provided to a Covered Person through telemedicine or store and forward technology, if:

- The plan provides coverage of the health care service when provided in person by the provider.
- The health care service is Medically Necessary.
- The health care service is recognized as an Essential Health Benefit (EHB) in accordance with provisions of the ACA.

For purposes of this benefit:

"Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

"Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services, and:

- The Covered Person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with a contracted provider who participates in our Network, and provides audio-only telemedicine; or
- The Covered Person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the Covered Person and has provided relevant medical information to the provider providing audio-only telemedicine;

"Originating site" means the physical location of a patient receiving health care services through telemedicine. Examples include:

- Hospital.
- Rural health clinic.
- Federally qualified health center.
- Physician's or other health care provider's office.
- Community mental health center.
- Skilled nursing facility.
- Renal dialysis center; except an independent renal dialysis center.
- Home, or any location determined by the Covered Person receiving the service.

"Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.

"Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile, or email.

Benefits are not available for services that are not a covered Benefit, or for services, if the originating site or provider is not a Network facility or physician.

Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under Virtual Care Services.

Benefits are also provided for Remote Physiologic Monitoring.

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. Please see *Section 1: Covered Health Care Services* or a Rider to the Policy for services that are specifically covered.

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. Aromatherapy.
2. Hypnotism.
3. Rolfing.
4. Wilderness, adventure, camping, outdoor, or other similar programs.
5. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. Please note that Benefits for Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided are described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in *Section 1: Covered Health Care Services*. Please note that Benefits for acupuncture or massage therapy for which Benefits are provided are described under *Acupuncture Services* and *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* 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).

Please note that Benefits for accident-related dental services for which Benefits are provided, are described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

Benefits for hospitalization and anesthesia for which Benefits are provided, are described under *Dental Services - Hospitalization and Anesthesia* in *Section 1: Covered Health Care Services*.

Please note that Benefits for dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, are covered under *Section 1: Covered Health Care Services* under *Dental Services - Hospitalization and Anesthesia* and *Dental Services - Accident Only*, but are 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.

Please note that Benefits for 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 are described under *Preventive Care Services* in *Section 1: Covered Health Care Services*. Benefits for accident-related dental services for which Benefits are provided are described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. Please note that Benefits for accident-related dental services for which Benefits are provided are described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).

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. Please note that Benefits for cranial molding helmets and cranial banding that meet clinical criteria, would be covered under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*. Please note that Benefits for braces for which Benefits are provided are 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.
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

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. Please note that orally administered anti-cancer medication used to kill or slow the growth of cancerous cells, for which Benefits are provided, are described under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services* if this Policy does not include an *Outpatient Prescription Drug Rider*. If the *Outpatient Prescription Drug Rider* is included, please see the *Outpatient Prescription Drug Rider* for coverage for orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.
2. Self-administered or self-infused medications. Please note that 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, may be provided as described under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*. Please note that services received from certain hemophilia treatment centers that are contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion, may be available under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*. Please note that insulin, for which Benefits are provided, are described under *Diabetes Services* in *Section 1: Covered Health Care Services*. Please note that Benefits for self-administered anti-cancer medications are provided under the *Outpatient Prescription Drug Rider*.
3. Non-injectable medications given in a Physician's office. Please note that Benefits for non-injectable medications that are required in an Emergency and used while in the Physician's office, are covered under *Physician Office Services - Sickness and Injury* in *Section 1: Covered Health Care Services*.
4. Over-the-counter drugs and treatments. Please note that Benefits for over-the-counter drugs that meet the requirements of a PPACA Zero Cost Share Preventive Care Medications are described under the *Outpatient Prescription Drug Rider*.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date they are reviewed, but no later than December 31st of the following calendar year.

Please note that if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), Benefits may be available under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*. Please note, 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, as described, 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. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. 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.
11. 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.
12. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
13. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

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

Please note that Benefits for prescription drugs which have not yet been approved by the *Food and Drug Administration (FDA)* for a particular indication, may be available under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*, if the prescribed drug has been recognized as safe and effective for treatment of a particular indication in one or more of the following:

- In one of the following standard reference compendia:
 - ♦ *The American Hospital Formulary Service Drug Information.*
 - ♦ *The American Medical Association Drug Evaluation.*
 - ♦ *The United States Pharmacopoeia Drug Information.*
 - ♦ Other authoritative compendia as identified from time to time by the *Federal Secretary of Health and Human Services* or the insurance commissioner.
- In the majority of relevant peer reviewed medical literature if not recognized in one of the standard reference compendia.
- By the *Federal Secretary of Health and Human Services*.

Please note that Covered Health Care Services provided during a clinical trial for which Benefits are provided are described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

F. Foot Care

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

Please note that Benefits for preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease, for which Benefits are provided, are described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

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

G. Medical Supplies and Equipment

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

Please note:

- 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*. The supplies necessary for the administration of medical food products are described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
 - Diabetic supplies for which Benefits are provided are described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
 - Ostomy supplies for which Benefits are provided are described under *Ostomy Supplies* in *Section 1: Covered Health Care Services*.
 - Urinary catheters and related urologic supplies for which Benefits are provided are described under *Urinary Catheters* in *Section 1: Covered Health Care Services*.
2. Tubings and masks. Please note that Benefits for tubings and masks when used with DME are 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 Chemical Dependency/Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Chemical Dependency/Substance-Related and Addictive 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* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Mental Health Services as treatments for V-codes 302-302.9 conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Please note that Medically Necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with federal law, for which Benefits are provided, are described under Section 1: Covered Health Care Services, under *Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
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, (including recovery residences).
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. Please note that Benefits for preventive care are provided under the *United States Preventive Services Task Force* requirement. Also note that Benefits for medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals, are described under *Physician Office Services - Sickness and Injury* and under *Preventive Care Services* in *Section 1: Covered Health Services*, when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is a part of treatment.
 - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*. Please note that Benefits for donor breast milk for certain circumstances are described under *Pregnancy – Maternity Services* in *Section 1: Covered Health Care Services*. See the Benefits for eosinophilic gastrointestinal disorder formula described under the *Outpatient Prescription Drug Rider* when this Policy includes coverage for prescription drugs.
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. See the Benefits for eosinophilic gastrointestinal disorder formula described under the *Outpatient Prescription Drug Rider* when this Policy includes coverage for prescription drugs..

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. Please note that Benefits for breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement, are 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, Cosmetic Surgeries and Cosmetic Services are not covered. See the definition in *Section 9: Defined Terms*. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. 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. Please note that Benefits for liposuction for reconstructive purposes, for which Benefits are provided, would be covered under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means. Please note that Benefits for hair removal as part of Medically Necessary gender affirming treatment, prescribed by a Physician for the treatment of gender dysphoria, would be provided as described under *Gender Dysphoria* in *Section 1: Covered Health Care Services*.
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. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Please note that Benefits for those services on the A & B list of preventive services as recommended by the *U.S. Preventive Services Task Force* are described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
5. 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. Please note that Benefits provided as a part of treatment for documented obstructive sleep apnea, will be provided under *Section 1: Covered Health Care Services*.
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 impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly. Please note that Benefits for Neurodevelopment Therapy for which Benefits are provided are described under *Neurodevelopment Therapy* in *Section 1: Covered Health Care Services*.

6. Habilitative services for maintenance/preventive treatment.
7. 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.
8. Biofeedback.
9. Services for the evaluation and treatment of TMJ, whether the services are considered to be medical or dental in nature.
10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. Please note that Benefits for reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment, for which Benefits are provided, are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
11. Surgical and non-surgical treatment of obesity. Please note that Benefits for those services on the A & B list of preventive services as recommended by the *U.S. Preventive Services Task Force* are described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
14. Helicobacter pylori (*H. pylori*) serologic testing.
15. Intracellular micronutrient testing.

M. Providers

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.

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Please note that Benefits for health care services and related expenses for infertility treatments, including assisted reproductive technology are described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
2. The following services related to a Gestational Carrier or Surrogate:
 - All costs related to reproductive techniques including:
 - ♦ Assisted reproductive technology.
 - ♦ Artificial insemination.
 - ♦ Intrauterine insemination.
 - ♦ Obtaining and transferring embryo(s).
 - ♦ Preimplantation Genetic Testing (PGT) and related services.
 - Health care services including:
 - ♦ Inpatient or outpatient prenatal care and/or preventive care.
 - ♦ Screenings and/or diagnostic testing.

- ♦ Delivery and post-natal care.

Please note that Benefits for the health care services listed above when the Gestational Carrier or Surrogate is a Covered Person are described under *Infertility Services and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.

- All fees including:
 - ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
 - ♦ Surrogate insurance premiums.
 - ♦ Travel or transportation fees.
- 3. Costs of donor eggs and donor sperm.
- 4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. Please note that coverage provided for short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided are described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
- 5. The reversal of voluntary sterilization.
- 6. Fetal reduction surgery.
- 7. Elective fertility preservation.
- 8. In vitro fertilization regardless of the reason for treatment. Please note that Benefits for in vitro fertilization for which Benefits are provided are described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.

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. For example, Benefits will not be paid for any Injury, Sickness or Mental Illness when coverage has been elected under workers' compensation, or similar legislation.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services during active military duty.

P. Transplants

1. Health care services for organ and tissue transplants. Please note that benefits for health care services for organ and tissue transplants, when covered, are 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.
4. Transplant services not received from a Designated Provider. Please note that Benefits for cornea transplants, for which Benefits are provided, are described under *Transplants Services* in *Section 1: Covered Health Care Services*.

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 or other Network provider may be paid back. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*.

R. Types of Care

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

S. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. 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 we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders. Please note that coverage will be provided for court ordered treatment when Medically Necessary.
 - Conducted for purposes of medical research. Please note that Covered Health Care Services provided during a clinical trial for which Benefits are provided are described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
 3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
 7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Autopsy.
 10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

 For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
 12. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding

Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year. Please note that health care services from an out-of-Network provider for non-emergent, sub-acute inpatient or outpatient services, in the case of an Emergency when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, may be available under *Emergency Health Care Services - Outpatient* in *Section 1: Covered Health Care Services*.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

Eligibility for enrollment is administered by the Group consistent with the Policy which includes this *Certificate* and *Group Application*.

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 in accordance with the eligibility rules. 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. The date of placement for adoption is the date that the Subscriber assumes legal obligation for total or partial support of a child. Physical placement in the home is not a requirement.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Except as described below for newborn and adopted children, coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 60 days of the event.

If no additional Premium is required, you are not required to notify us of a new Dependent who is eligible by reason of birth, adoption or placement for adoption. Coverage begins on the date of birth, adoption or placement for adoption. Coverage includes, but is not limited to, Benefits for the treatment of a Congenital Anomaly. However, for prompt payment of subsequent claims for your new Dependent, please complete an enrollment form and send it to us at your earliest convenience.

If additional Premium is required, you must notify us within the first 60 days after the birth, adoption or placement for adoption. If you fail to notify us of the child's birth, coverage will end after the first 21 days following birth.

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. Newborns are automatically covered for the first 3 weeks from birth. For newborns, coverage includes, but is not limited to, Benefits for the treatment of a Congenital Anomaly from the date of birth. If additional premium is required for adding the newborn, in order for coverage to continue beyond the first 3 weeks of life, the Subscriber must submit a change request form to UnitedHealthcare within 60 days from the date of birth. Coverage for the new Dependent begins on the date of birth.
- Legal adoption. If additional premium is required, as a result of adding the adopted child, the Subscriber must submit a change request form to UnitedHealthcare within 60 days of the date of placement for adoption. Coverage for the Dependent begins on the date of the placement for adoption.
- Placement for adoption. If additional premium is required, as a result of adding the adopted child, the Subscriber must submit a change request form to UnitedHealthcare within 60 days of the date of placement for adoption. Coverage for the Dependent begins on the date of the placement for adoption.
- Marriage.
- Registering a Domestic Partner.

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (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.
 - Meeting or exceeding lifetime limits on the prior plan.
 - Discontinuation of the prior plan.
 - Termination or reduction in the number of hours worked.
 - Cessation of dependent status, (e.g., reach maximum age).

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

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on

the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage under the prior plan ended.

A special enrollment period also applies when the *Washington Department of Social and Health Services* determines that it is cost effective to enroll a person eligible for medical assistance under RCW 74.09 or a child that is participating in a medical assistance program under RCW 74.09, in an employer-sponsored health plan. In this case, there are no open enrollment restrictions for the Eligible Person. The request for special enrollment of a child must be made by the Subscriber or *WDSHS* within 60 days of the Department's determination that the enrollment would be cost-effective.

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.

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).

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

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 rules. 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 Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond 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 for support.

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

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age.

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

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

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.

Continuation Coverage During a Labor Dispute

If the Subscriber's compensation includes group medical insurance for which the Premiums are paid in full or in part by the Group, or are paid by payroll deduction, the Subscriber may pay the full amount of the Premium directly to the Group whenever the Subscriber's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute for a period not to exceed six months.

During the period of the strike, lockout, or other labor dispute the Policy will not be altered or changed, except that Premiums may change in accordance with the provision of the Policy.

When the Subscriber's compensation is suspended or terminated, the Group will notify the Subscriber in writing, by mail addressed to the address last on record with the Group, that the Subscriber may pay the Premiums to the Group as they become due. The Group will remit any Premiums paid to us.

The continuation of coverage will be on a monthly renewal basis until the earlier of the following:

- The end of the period for which the last Premium is paid.
- The date that the Subscriber takes full-time employment with another employer.
- The date 6 months after compensation is suspended or terminated as the result of a strike, lockout or other labor dispute.
- Upon termination of this provision for continuation of coverage during labor disputes, Covered Persons will be entitled to convert such coverage to an individual plan.

Family Medical Leave (FMLA)

You may be eligible for continued coverage under the *Family Medical Leave Act (FMLA)*. The *Family Medical Leave Act (FMLA)* entitles an Eligible Person of the Group to take unpaid, job protected leave for specified family and medical reasons with continuation of group health coverage under the same terms and conditions as if the employee had not taken leave.

Eligible Persons are entitled to:

- Twelve work weeks of leave in a 12-month period for:
 - The birth of a child and to care for the newborn child within one year of birth;
 - The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
 - To care for the employee's spouse, child, or parent who has a serious health condition;
 - A serious health condition that makes the employee unable to perform the essential functions of his or her job;
 - Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty"; or
- Twenty six work weeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the Eligible Person is the service member's spouse, son, daughter, parent, or next of kin.

You can contact your plan administrator to determine if you are eligible for continued coverage under the *Family Medical Leave Act (FMLA)*. If you are eligible to continue coverage under this provision, the Covered Person must make timely payments of the monthly rates to the Group for remittance to us. The Group is responsible for notifying us if you are eligible for coverage under the *Family Medical Leave Act (FMLA)*.

All coverage under this provision ends automatically on the date the Policy is terminated.

Three Month Continuation Coverage under State Law

The three-month continuation of coverage provision offers you continued coverage when your coverage under the group Policy ends.

This continued coverage applies to Covered Persons when the Group is not required by federal law to offer continued coverage. It also offers continued coverage to Covered Persons who are not eligible for continued coverage under the federal laws and regulations collectively referred to as *COBRA*. When such a Covered Person's coverage under the Policy ends, the Covered Person may continue coverage for a period not to exceed three months.

A Covered Person whose *COBRA* coverage ends less than three months after it began can continue coverage under this Policy for the balance of the three-month period. Covered Persons whose *COBRA* coverage is in force for at least three months in a row are not eligible for this continued coverage when the Covered Person's *COBRA* coverage ends.

To continue coverage under this provision, the Covered Person must make timely payments of the monthly rates to the Group for remittance to us. At the end of the three-month period, the Covered Person may apply for and receive the individual conversion option.

All coverage under this provision ends automatically on the date the Policy is terminated.

Conversion

The Subscriber and any Enrolled Dependents may apply for coverage under an individual conversion plan. However, if the Subscriber's employment is terminated due to misconduct, only the Enrolled Dependents may apply. The Group is solely responsible for notifying Covered Persons of the availability, terms and conditions of the individual conversion plan within 15 days of the termination of Covered Person's group coverage.

You will not be permitted to transfer to the individual conversion health plan under any of the following circumstances:

- You failed to pay any Premiums.
- Your coverage was terminated for fraud or misrepresentation.
- You knowingly furnished incorrect information or otherwise improperly obtained Benefits under the Policy.
- You are covered under or eligible for Medicare.
- You are covered or eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured.
- You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in a Covered Person's group plan.

An individual conversion health plan is available to the Subscriber as well as to:

- Enrolled Dependents, when the Subscriber dies.
- Enrolled Dependents, when the Subscriber's employment terminates.
- Enrolled Dependent children who exceed the maximum age for Dependent coverage under the Policy.
- Enrolled Dependents, when the Subscriber enters military service.
- The Enrolled Dependent spouse of the Subscriber, when the marriage terminates.

We must receive written applications for all conversion coverage within 31 days of the loss of group coverage or thirty-one days after the date the person received notice of termination of coverage, whichever is later. For more details, please call the telephone number shown on your ID card.

NOTE: If you accept conversion coverage at the end of coverage under a group health plan or at the end of *COBRA*, the Covered Person may give up some protections under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. This may include the ability to qualify as a *HIPAA* eligible individual. To retain that guarantee, most recent coverage must have been group health plan coverage.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

Required Information

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

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

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

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

Optum Rx
PO Box 650629
Dallas, TX 75265-0629

Payment of Benefits

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

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

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

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

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

Time of Payment of Claims

Benefits for incurred medical expenses for Covered Health Care Services will be paid upon our receipt of due written proof of such loss.

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. The information in this section is available to all Covered Persons, including assistance to those that are limited-English speakers, have literacy problems, or who have physical or mental disabilities that may impede their ability to file a grievance, appeal or review of an adverse benefit determination.

What if You Have a Complaint/Grievance?

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/grievance to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written or oral complaint. We will notify you of our decision regarding your complaint within 14 days of receiving it.

The definition of a Grievance is:

Grievance - a written or oral complaint submitted by or on behalf of a Covered Person regarding:

- Issues other than health care services or payment for health care services including:
 - Dissatisfaction with health care services.
 - Delays in obtaining health care services.
 - Conflicts with Network provider or our staff.
 - Dissatisfaction with our practices or actions unrelated to health care services.

What if You Disagree with Our Adverse Benefit Determination?

If you disagree with our Adverse Benefit Determination, you may file a formal appeal. Our internal review appeals procedures are designed to deliver a timely response and resolution to your appeal. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem. We will continue to provide coverage for the Covered Health Care Service under review until the appeal is resolved. Please note that if the appeal is overturned, you may be responsible for the Covered Health Care Service that was under review.

You may submit written comments, documents, records and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. You may designate a person, including an attorney, to act on your behalf.

The definition of an Adverse Benefit Determination is:

Adverse Benefit Determination - a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including:

- A denial, reduction, termination, or failure to provide or make payment that is based on a determination by the health carrier or its utilization review organization of a Covered Person's, or applicant's eligibility to participate in the carrier's health benefit plan;
- A rescission of coverage;
- A denial of an application for coverage;

- A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a determination made by the utilization review organization for a benefit that does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate;
- A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for a prospective review or retrospective review.

How Do You Appeal a Claim Decision?

How to Request an Appeal

If you disagree with our Adverse Benefit Determination, you can contact us in writing to request an appeal. To initiate the standard appeal, you may call or write us at the telephone number or address on your ID card. We will acknowledge receipt of your appeal in writing.

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 an authorization for Benefits or a claim denial.

You may also seek assistance from the *Washington State Office of the Insurance Commissioner* who can be reached at:

Washington State Office of the Insurance Commissioner

P.O. Box 40255

Olympia, WA 98504-0255

Phone: 1-800-562-6900 or (360) 725-7080

FAX: (360) 586-2018

Internal Review Appeal Process

The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal, nor the subordinate of that person. If your appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of the appeal. 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. You may designate a representative to file an appeal on your behalf by providing written notice that includes the issue in dispute, your signature and the representative's signature. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the Adverse Benefit Determination. If you need additional time to review any new or additional evidence relied upon or generated by us during the determination of the appeal, we will extend

the due date for the Adverse Benefit Determination for a reasonable amount of time, but no less than 2 days.

For determinations that the services are not Covered Health Care Services, the response will specify the provisions in the *Certificate* that exclude that coverage and will include information regarding your right to request an external review of the determination by an independent review organization.

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

If the appeal does not qualify as an urgent appeal or a concurrent expedited review, it will be reviewed as a standard appeal. We will provide a written response regarding the outcome within 14 calendar days from receipt of the appeal. If additional time for review is necessary, we will notify the Covered Person in writing and make a determination no later than 30 calendar days from the date of our receipt of the appeal.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We do not determine whether the pending health care service is appropriate. That 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.

Expedited Review and Concurrent Expedited Review

You may request an expedited internal or external review or concurrent expedited internal and external review of an Adverse Benefit Determination, as defined in *Section 9: Defined Terms*, if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or Benefits that would end because of the Adverse Benefit Determination.
- Your Physician believes that a delay in treatment based on the standard review times may seriously jeopardize your life, overall health or the ability to regain maximum function, or cause severe and intolerable pain.
- If the Adverse Benefit Determination is related to an admission, availability of care, continued stay, or Emergency Health Care Services and you have not been discharged from the emergency room or transport service.

You may not request an expedited review if the treatment has already been delivered and the review only involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease.

Call us at the telephone number shown on your ID card to request an expedited review of an Adverse Benefit Determination. An expedited review may be submitted orally or in writing by you, your authorized representative, or your Physician.

UnitedHealthcare will make a determination within 24 hours, when possible, but no later than 72 hours of our receipt of the request for expedited review of an Adverse Benefit Determination. A written response will also be sent no later than 72 hours after the decision is made.

Please see Independent External Review Program below for information on external review.

Experimental, Investigational or Unproven Treatment

We may deny Benefits for a treatment if we determine it to be an Experimental or Investigational or Unproven Service. You may request that we hold a conference within 20 days of receiving the request to review the denial. We will respond to you within 20 days of receipt of the fully documented appeal request. We may extend the review period beyond 20 days only with your informed written consent. Whenever you appeal our decision and a delay would jeopardize your life or health, we will make a decision in accordance with the timeframe described above under Urgent Appeals that Require Immediate Action.

Independent External Review Program

After you exhaust the appeal process, if we make a final determination to deny Benefits, you have the right to request an external review of our Adverse Benefit Determination, as defined in *Section 9: Defined Terms*, by an independent review organization. This external review program only applies if our decision is based on medical necessity, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Call us at the telephone number shown on your ID card for more information on the external review program.

We offer an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting our appeal process and you receive a decision that is unfavorable, or if we fail to respond to the appeal within the time lines stated above in the Appeals section.

Neither you nor we will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within 180 calendar days of the date you receive the denial. You, your treating Physician, or a designated representative may request an independent review by calling us at the telephone number on your ID card or by sending a written request to the address on your ID card.

An Independent Review Coordinator will be designated to address any questions you might have and to assist with the independent review process.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Care Service under the Policy, or for denials based on contract exclusions or language, by a person with expertise analyzing health coverage agreements. The *Independent Review Organization (IRO)* has no material affiliation or interest with us. We will choose the *IRO* based on a rotating list of approved *IROs* within the rotational registry system. We may not make an assignment to an *IRO* out of sequence for any reason other than the existence of conflict of interest.

In certain cases, the independent review will be performed by a panel of Physicians, as deemed appropriate by the *IRO*.

Within three business days of our receipt of a request for independent review, we will forward the request to the *IRO*, together with the following:

- All relevant medical records.
- All other documents relied upon by us in making a decision on the case.
- All other information or evidence that you or your Physician has already submitted to us.
- The attending or ordering provider's recommendations.

- A copy of the terms and conditions of coverage under this plan.
- If there is any information or evidence you or your Physician wish to submit in support of the request for Benefits for the service or procedure that has not previously been provided to us, you may include this information with the request for an independent review, and we will include it with the documents forwarded to the *IRO*. A decision will be made within 25 calendar days. If the reviewer needs additional information to make a decision, this time period may be extended. You may also submit within 5 business days, in writing and directly to the *IRO*, any additional information in support of the request for Benefits for the service or procedure.
- If we deny Benefits based upon a finding that the health care service or level of health care service is no longer Medically Necessary, you may continue to receive the health care service until the appeal is resolved. If it is determined that the appeal or other resolution you seek affirms our decision, you may be responsible for the cost of the continued health care service.

The independent review process will also be expedited if you meet all the criteria for independent review and the Physician certifies that the requested service or procedure would be significantly less effective if not promptly initiated. A decision will be made as soon as possible but not later than 72 hours after receipt of the request for expedited review.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The *IRO* will provide you and us with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization.

If the final independent decision is to approve payment of referral, we will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Policy.

If the final independent review decision is that payment or referral will not be made, we will not be obligated to provide Benefits for the service or procedure. You or your Physician, who want additional information about our independent review process may call the telephone number on your ID card.

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. All Benefits under the Policy are subject to this coordination provision.

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

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

Definitions

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

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; medical benefits under group or individual automobile contracts; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- 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. In addition, if This Plan is secondary, it must calculate its savings and record these savings as a benefit reserve for the Covered Person. This reserve must be used to pay any expenses during the calendar year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

- D. **Allowable Expense.** Allowable Expense is a health care expense, including co-insurance and co-payments, and without reduction for any applicable deductible(s), 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. When coordinating benefits, any Secondary Plans must pay an amount which, together with the payment made by the Primary Plan, cannot be less than the Allowable Expense the Secondary Plan would have paid if it was the Primary Plan. In no event will a Secondary Plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D are primary, Medicare's allowable amount is the 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, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- E. **Claim.** Claim means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of: (a) Services, including supplies; (b) Payment for all or a portion of the expenses incurred; (c) A combination of subsections (a) and (b); or (d) an indemnification.
- F. **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.
- G. **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. In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

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

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

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

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

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

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

- (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
- 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 make payment in an 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. However, in no event shall the Secondary Plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Covered Person be responsible for a deductible amount greater than the highest of the two deductibles.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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.

Notice to Covered Persons

If you are covered by more than one health benefit plan, and you do not know which is your Primary Plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days. CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

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. When Medicare is primary, Medicare's allowable amount is the Allowable Expense.

IMPORTANT NOTICE: Below is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in this *Certificate*, which determines your Benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The

goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your *Certificate of Coverage* or contact your state insurance department.

Primary or Secondary

You will be asked to identify all the plans that cover members of your family. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The Primary Plan always pays first when you have a claim.

Any plan that does not contain your state's *COB* rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- Your child's expenses. The claim is for the health care expenses of your child who is covered by This Plan; and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

- We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the Primary Plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the Secondary Plan, we will make payment promptly after receiving payment information from your Primary Plan. Your Primary Plan, and we as your Secondary Plan, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the Primary Plan fails to pay within sixty calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your Primary Plan. In such situations, we are required to pay claims within thirty calendar days of receiving your claim and the notice that your Primary Plan has not paid. This provision does not apply if Medicare is the Primary Plan. We may recover from the Primary Plan any excess amount paid under the "right of recovery" provision in the plan.

If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the Primary Plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the Primary Plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

We will determine our payment by subtracting the amount paid by the Primary Plan from the amount we would have paid if we had been primary. We must make payment in an 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 equal to one hundred percent of the total Allowable Expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the Primary Plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

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. The *Notice of Privacy Practices* is provided annually to each Covered Person and is also available by accessing www.myuhc.com.

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, when applicable.
- 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.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in the *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You

may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative 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. Please contact us at www.myuhc.com or by calling the telephone number on your ID card, if you have any questions.

Who Interprets Benefits and Other Provisions under the Policy?

We will do all of the following:

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

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 from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, if there are changes in federal or state laws, we have the right, 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*. The *Notice of Privacy Practices* is provided annually to each Covered Person and is also available by accessing www.myuhc.com.

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, including provider billing and provider payment records. 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. We maintain the privacy of your records as required by the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule* and, to the extent that the laws of the State of Washington are more stringent in regard to your privacy, we comply with the laws of the State of Washington. Please refer to our *Notice of Privacy Practices*.

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

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

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

Do We Require Examination of Covered Persons?

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

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.

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 applies when we have paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which any third party is considered responsible.

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.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

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.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- We may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. Our reimbursement rights shall be limited to the excess of the amount required to fully compensate you for the loss sustained.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.

- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We may resolve disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

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 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.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

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

Advanced Genetic Testing - genetic tests that include panels of multiple genes (DNA and/or RNA) or use data algorithms to determine the risk of developing a specific disease or disorder or to provide information to guide the selection of treatment.

Adverse Benefit Determination - a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including:

- A denial, reduction, termination, or failure to provide or make payment that is based on a determination by the health carrier or its utilization review organization of a Covered Person's, or applicant's eligibility to participate in the carrier's health benefit plan;
- A rescission of coverage;
- A denial of an application for coverage;
- A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a determination made by the utilization review organization for a benefit that does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate;
- A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for a prospective review or retrospective review.

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

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

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines after review of all provider billings generally 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-Related and Addictive Disorders Services on an outpatient or inpatient basis.

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

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

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

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

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

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

Chemical Dependency/Substance Use Disorder - an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the Covered Person exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if used of the controlled substance or alcoholic beverage is reduced or discontinued; and the Covered Person's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

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

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

Congenital Anomaly - a physical developmental defect that is present at the time of birth. For the purposes of clarification, Congenital Anomaly includes congenital abnormalities.

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 or the Recognized Amount when applicable.

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

Cosmetic Services and Surgery - Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance.

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group eligibility for enrollment and qualification as a Dependent is administered by the Group consistent with the eligibility rules noted in the Policy which includes this *Certificate* and the *Group Application*. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- 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*. Status as a Dependent will not be affected by the parent's marital status at the time of a child's birth, support and maintenance requirements for tax purposes, or residence requirements.

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 during which the child reaches age 26 except as provided in *Section 4: When Coverage Ends under Coverage for a Disabled Dependent Child*.

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

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

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

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

Designated 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 conditions; 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 with video technology or audio only.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a state registered domestic partnership.

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 rules in accordance with the Policy which includes this *Certificate* and the *Group Application*. An Eligible Person must live within the United States.

Emergency - means the emergent and acute onset of symptom or symptoms, including severe pain or emotional distress that would lead a Prudent Layperson, acting reasonably, to believe that a health condition exists that requires immediate medical attention, mental health or substance use disorder treatment, and failure to provide medical attention, mental health or substance use disorder treatment could reasonably be expected to result in any of the following:

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

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam, including a behavioral health emergency screening examination (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency

Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).

- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

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

For purposes of this definition, behavioral health emergency services providers means emergency services provided in the following settings:

- A crisis stabilization unit as defined in RCW 71.05.020;
- An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder and which is licensed or certified as such by the department of health;
- An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;
- A triage facility as defined in RCW 71.05.020;
- An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or
- A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

Emergency Health Care Services includes Medically Necessary detoxification when provided in a licensed Hospital.

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
 - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
 - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
 - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.
5. In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the *State of Washington*, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.
6. In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient.

Exceptions:

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

Grievance - a written or oral complaint submitted by or on behalf of a Covered Person regarding:

- Issues other than health care services or payment for health care services including:
 - Dissatisfaction with health care services.
 - Delays in obtaining health care services.
 - Conflicts with Network provider or our staff.
 - Dissatisfaction with our practices or actions unrelated to health care services.

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

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

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

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

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

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

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary - health care services that are all of the following:

- 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 have the right to consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons, free of charge, 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 and Chemical Dependency/Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental Health 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 American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Mental Health Care Services - Inpatient or outpatient treatment, partial hospitalization, outpatient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize or ameliorate the effects of a mental disorder categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV* published by the *American Psychiatric Association*, including diagnosis and treatment for substance use disorder. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

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

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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 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.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - 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: (a duly licensed or certified practitioner of the healing arts, including, but not limited to, a registered nurse, advanced registered nurse practitioner, acupuncturist, podiatrist, dentist, psychologist, chiropractor, optometrist, licensed/certified midwife, physician assistant, pharmacist, who is practicing within the scope of his or her license), group facility or other entity that is licensed or otherwise qualified to deliver any of the Covered Health Care Services, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *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.

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

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

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

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

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

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

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

Prudent Layperson - a person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Health Care Services are needed.

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

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following:

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

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

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

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

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

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

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Area - our service area is statewide and includes all counties in Washington.

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.

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.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may 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.
- We may consider an otherwise Unproven Service to be a Covered Health Care Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*- approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Care Service may be considered by us. Other apparently similar promising but unproven services may not qualify.

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.

Section 10: Consolidated Appropriations Act Summary

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act")* (P.L. 116-260).

No Surprises Act

Balance Billing

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

For the purpose of this Summary, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine our payment to out-of-Network providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR)*.

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

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

Discrimination is against the law. UnitedHealthcare complies with applicable federal and Washington state civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, creed, religious affiliation, political beliefs, sex, gender identity or expression, or sexual orientation.

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by us. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

**Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance**

P.O. Box 30608

Salt Lake City, UT 84130

Email: UHC_Civil_Rights@uhc.com

You can also file a civil rights complaint with:

The U.S. Department of Health and Human Services Office for Civil Rights:

Online: **hhs.gov/civil-rights/filing-a-complaint/index.html**

By mail: U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D.C. 20201

By phone: 1-800-368-1019 (TDD 1-800-537-7697)

Washington State Office of the Insurance Commissioner

Online: <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>

PO Box 40255

Olympia, WA 98504-0255

By phone: **1-800-562-6900** (TDD **360-586-0241**)

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services at 1-866-375-3257, TTY 711, 8 a.m.–6 p.m. EST, Monday–Friday

UnitedHealthcare Choice Plus

UnitedHealthcare of Washington, Inc.

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.

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

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

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

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

You must see a Choice Network Physician in order to receive Network Benefits. You can confirm that your provider is a Choice Network provider by contacting us at www.muuhc.com or the telephone number on your ID card.

Women have direct access to, and may seek care, directly from any Choice Network obstetrician or gynecologist, Family Practice Physician or surgeon, osteopathic physician or surgeon, licensed physician assistant or licensed osteopathic physician assistant, licensed midwife or licensed nurse midwife without a referral or authorization requirement for covered women's healthcare services. You and Enrolled Dependents may also obtain services directly from a chiropractor, affiliated with UnitedHealthcare, without a referral or prior authorization requirement.

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.

Standing Referrals to Specialists

A standing referral is a referral by your Primary Care Physician that authorizes more than one visit to another Network Physician or Specialist. A standing referral may be provided if your Primary Care

Physician, in consultation with you and the other Network Physician, Specialist, or UnitedHealthcare Medical Director, determines that as part of a treatment plan you need continuing care from a specialist. You may request a standing referral from your Primary Care Physician or UnitedHealthcare.

Please Note: A standing referral and treatment plan is only allowed if approved by your Primary Care Physician or UnitedHealthcare.

Does Prior Authorization Apply?

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

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

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

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

Utilization Review

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. Our utilization review process timeframes are conducted in a timely manner appropriate to the severity of the patient's condition and the urgency of the need for treatment. We will make clinical review criteria available upon request to Network providers.

If a coverage determination is requested at the time prior authorization is provided, the determination will be made based on the reported services that 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.

For prior authorizations submitted through an electronic prior authorization process, as designated by the carrier, the following timelines will apply:

- For electronic standard prior authorization requests, within three calendar days, excluding holidays, if the information provided is sufficient to make a determination. If the information provided is not sufficient to make a decision, we will request additional information within one calendar day of submission of the electronic prior authorization.
- For electronic expedited prior authorization requests, within one calendar day if the information provided contains the necessary information to make a decision. If the information provided is not sufficient to make a decision, we will request additional information within one calendar day of submission of the electronic prior authorization.

For prior authorization requests received through a process other than an electronic process, if the review request from the provider is not accompanied by all necessary information, we will notify the provider

what additional information is needed and the deadline for its submission. Upon the receipt of all necessary information or the expiration of the deadline for providing information, we will review the request for determination within the following timelines:

- For immediate review requests, within one business day when the lack of treatment may result in an Emergency visit or Emergency admission;
- For concurrent review requests that are also urgent care review requests, as soon as reasonably possible, taking into account the medical exigencies, but no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of the previously approved period of time or number of treatments;
- For urgent care review requests:
 - Must approve the request within forty-eight hours if the information provided is sufficient to approve the claim;
 - Must deny the request within forty-eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or
 - Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, we will request additional information from the provider in order to make the prior authorization determination. The provider has forty-eight hours to provide us with the additional information. Upon receipt of the additional information the request will be approved or denied within forty-eight hours.
- For non-urgent care review requests:
 - Must approve the request within five calendar days if the information provided is sufficient to approve the claim;
 - Must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or
 - Within five calendar days, if the information provided is not sufficient to approve or deny the claim, we will request additional information from the provider in order to make the prior authorization determination. The provider has five calendar days to provide us with the additional information. Upon receipt of the additional information the request will be approved or denied within four calendar days.
- For post-service review requests, within thirty calendar days.

Notification of the Determination

We will provide the attending Physician, ordering provider, facility, and Covered Person with written or electronic notification of our determination or you may call us the telephone number on your ID card.

Whenever there is an adverse determination we will notify the ordering provider or facility and the Covered Person in advance and indicate whether the notification will be provided by telephone, mail, fax, or other means. For an adverse determination involving an urgent care review request, we may initially provide notice by telephone, provided that a written or electronic notification meeting the *United States Department of Labor* standards is furnished within three days of the oral notification.

The notification will include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

The frequency of reviews for the extension of initial determination must be based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

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

"Concurrent care review request" means any request for an extension of previously authorized Inpatient Stay or a previously authorized ongoing outpatient services.

"Immediate review request" means any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the provider, result in an imminent Emergency room visit or Hospital admission and deterioration of the patient's health status. Examples of situations that do not qualify under an immediate review request include, but are not limited to, situations where:

- The requested service was pre-scheduled, was not an Emergency when scheduled, and there has been no change in the patient's condition;
- The requested service is Experimental or Investigational Service or in a clinical trial;
- The request is for the convenience of the patient's schedule or provider's schedule; and
- The results of the requested service are not likely to lead to an immediate change in the patient's treatment.

"Non-urgent pre-service review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services and is not an urgent care request.

"Post-service review request" means any request for approval of care or treatment that has already been received by the patient.

"Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Benefits for insulin under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table. Any amount that you pay for Covered Health Care Services that is applied to the Network Annual Deductible will be applied to the Out-of-Network Annual Deductible. Any amount you pay for Covered Health Care Services that is applied to the Out-of-Network Annual Deductible will be applied to the Network Annual Deductible.	Network \$1,500 per Covered Person, not to exceed \$3,000 for all Covered Persons in a family. Out-of-Network \$1,500 per Covered Person, not to exceed \$3,000 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 for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.	Network \$6,350 per Covered Person, not to exceed \$12,700 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. Out-of-Network \$6,350 per Covered Person, not to

Payment Term And Description	Amounts
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, when applicable. - 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. Any amount that you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will be applied to the Out-of-Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the Out-of-Network Out-of-Pocket Limit will be applied to the Network Out-of-Pocket Limit.	exceed \$12,700 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 or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> 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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Acupuncture Services			
Limited to 12 treatments per year. Benefits for acupuncture for the treatment of Chemical Dependency as described under Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services are not subject to the limit stated above.	Network \$35 per visit	Yes	No
	Out-of-Network 50%	Yes	Yes
2. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services(including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network Ground Ambulance 20% Air Ambulance 20%	Yes Yes	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>Out-of-Network</i> Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	<i>Network</i> <i>Ground Ambulance</i> 20% <i>Air Ambulance</i> 20%	Yes Yes	Yes Yes
	<i>Out-of-Network</i> <i>Ground Ambulance</i> 20% <i>Air Ambulance</i> Same as Network	Yes Same as Network	Yes Same as Network
3. Cellular and Gene Therapy			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	<i>Network</i> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services –</i>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.				
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.				
Covered Health Care Service		What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
		<i>Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		
		Out-of-Network Out-of-Network Benefits are not available.		
4. Clinical Trials				
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.				
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		
		Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		
5. 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				

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
will be increased to 50% of the Allowed Amount.			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
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 <i>Schedule of Benefits</i> .	Network Benefits will be the same as stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .		
	Out-of-Network Benefits will be the same as stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .		
6. Dental Services - Accident Only			
	Network 20%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network
7. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
be responsible for paying all charges and no Benefits will be paid.			
Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
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 <i>Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		
	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 <i>Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> .	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 <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
8. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Benefits will be paid. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Benefits are limited to a single purchase of a type of DME or orthotic every year. 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. To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	Network 20%	Yes	Yes
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
9. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service.	Network 20% after you pay \$200 per visit.	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
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. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .			
	Out-of-Network Same as Network	Same as Network	Same as Network
10. Enteral Nutrition			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
11. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to \$20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under <i>Preimplantation Genetic</i>	Network 20%	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<i>Testing (PGT) and Related Services.</i> Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.			
	Out-of-Network 50%	Yes	Yes
12. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you. It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you. Prior Authorization Requirement for Non-Surgical Treatment Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies, Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; and Prosthetic Devices</i> in this <i>Schedule of Benefits</i>.			
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with outpatient speech therapy limits as described under <i>Habilitative Services and Rehabilitation Services - Outpatient</i>	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental</i>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Certificate, Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Therapy and Manipulative Treatment.	Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures 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 Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures in this Schedule of Benefits and in the Outpatient Prescription Drug Rider.		
13. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	Network Inpatient Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services 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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Outpatient therapies: - Physical therapy. - Occupational therapy. - Manipulative Treatment. - Speech therapy. - Post-cochlear implant aural therapy. - Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment. The limits stated above do not apply to Applied Behavioral Analysis or other therapy services for treatment of autism spectrum disorder diagnoses, subject to medical necessity and clinical appropriateness. The limits above do not apply to Neurodevelopmental therapy or other types of therapy which may be provided as treatment of autism spectrum disorder or other mental health diagnoses if the therapy is deemed medically necessary and appropriate.	<i>Outpatient</i> \$35 per visit	Yes	No
	<i>Out-of-Network</i> <i>Inpatient</i> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i> in this <i>Schedule of Benefits</i>.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Outpatient 50%	Yes	Yes
14. Hearing Aids			
Network Benefits include services and one hearing aid per ear up to \$3,000 every 36 months not subject to deductible. Costs exceeding the above coverage amount are subject to the applicable deductible and Co-insurance. Repair and/or replacement of a hearing aid would apply in the same manner as a purchase.	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
15. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Limited to 130 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	Network 20%	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
provider we identify.			
	Out-of-Network 50%	Yes	Yes
16. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
17. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	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 or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
18. 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. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Lab Testing - Outpatient	Network None	Yes	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
X-Ray and Other Diagnostic Testing - Outpatient	Network None	Yes	No
	Out-of-Network 50%	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
19. 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 is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
20. Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits, for a scheduled admission for Mental Health Care and Chemical Dependency/Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including <i>Applied Behavior Analysis (ABA)</i>. If you do not obtain prior authorization as required, the amount you are required to pay will be increased			

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 or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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

to 50% of the Allowed Amount.

Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.

	<i>Network</i> <i>Inpatient</i> 20%	Yes	Yes
	<i>Outpatient Office Visits</i> \$35 per visit	Yes	No
	<i>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</i> 20%	Yes	No
	<i>Intensive Behavioral Therapy</i> 10%	Yes	No
	<i>Out-of-Network</i> <i>Inpatient</i> 50%	Yes	Yes
	<i>Outpatient Office Visits</i> 50%	Yes	Yes
	<i>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive</i>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>Outpatient Treatment</i> 50%	Yes	Yes
	<i>Intensive Behavioral Therapy</i> 50%	Yes	Yes
21. Ostomy Supplies			
	Network 20%	Yes	Yes
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
22. Pharmaceutical Products - Outpatient			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
23. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Network 20%	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network 50%	Yes	Yes
24. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. Note: When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above.	Network \$35 for a Primary Care Physician office visit or \$35 per visit for a Specialist office visit	Yes	No
	Out-of-Network 50%	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
25. Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
	Out-of-Network Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services – Sickness and Injury</i> in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
26. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
the same as, and combined with, those stated under <i>Fertility Preservation for Iatrogenic Infertility</i> . This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i> .	20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
27. Preventive Care Services			
Physician office services	Network None	No	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
Lab, X-ray or other preventive tests	Network None	No	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
Breast pumps	Network None	No	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
28. 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. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Benefits are limited to a single purchase of each type of prosthetic device every year. 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 <i>Women’s Health and Cancer Rights Act of 1998</i> .	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
29. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury and Prosthetic Devices</i> in this <i>Schedule of Benefits</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury and Prosthetic Devices</i> in this <i>Schedule of Benefits</i> .		
30. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: 25 visits of physical therapy. 25 visits of occupational therapy. 25 visits of Manipulative Treatment. 20 visits of massage therapy. 25 visits of speech therapy. 25 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 25 visits of cognitive rehabilitation therapy. The limits stated above do not apply to Applied Behavioral Analysis or other	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
therapy services for treatment of autism spectrum disorder diagnoses, subject to medical necessity and clinical appropriateness. The limits above do not apply to Neurodevelopmental therapy or other types of therapy which may be provided as treatment of autism spectrum disorder or other mental health diagnoses if the therapy is deemed medically necessary and appropriate.			
	Out-of-Network 50%	Yes	Yes
31. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
32. Skilled Nursing Facility/Inpatient Rehabilitation 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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
Limited to 60 days per year.	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
33. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network 20%	Yes	Yes
	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	50%	Yes	Yes
34. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before TMJ services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury, and Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>.		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury, and Surgery - Outpatient</i> in this <i>Schedule of Benefits</i>.		
35. 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,			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network 20%	Yes	Yes
	Out-of-Network 50% For dialysis services, Out-of-Network Benefits are not available.	Yes For dialysis services, Out-of-Network Benefits are not available.	Yes For dialysis services, Out-of-Network Benefits are not available.
36. Transplantation Services			
Prior Authorization Requirement			
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Lab, X-Ray and Diagnostics – Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services – Sickness and Injury, and Surgery - Outpatient</i> in this <i>Schedule of Benefits</i> .		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Out-of-Network Out-of-Network Benefits are not available.		
37. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center:	Network \$35 per visit	Yes	No
- Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. - Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. - Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. - Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.			
	Out-of-Network 50%	Yes	Yes
38. Urinary Catheters			
	Network 20%	Yes	Yes
	Out-of-Network Out-of-Network Benefits are not	Out-of-Network Benefits are not	Out-of-Network Benefits are not

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	available.	available.	available.
39. Virtual Care Services			
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 <i>Urgent Care</i> None	Yes	No
	Out-of-Network Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
Additional Benefits Required By Washington Law			
40. Abortion of a Pregnancy			
	Network None	Yes	No
	Out-of-Network 50%	Yes	Yes
41. Dental Services - Hospitalization and Anesthesia			
Prior Authorization Requirement			
For Out-of-Network Benefits you must notify us five business days before dental anesthesia is 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.			
Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	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 <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i> , Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Physician Fees for Surgical and Medical Services; and Surgery - Outpatient</i> in this <i>Schedule of Benefits</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay; Physician Fees for Surgical and Medical Services; and Surgery - Outpatient</i> in this <i>Schedule of Benefits</i> .		
42. Neurodevelopment Therapy			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). Network providers are responsible for obtaining prior authorization before they provide Covered Health Care Services to you.			
	Network \$35 per visit	Yes	No
	Out-of-Network 50%	Yes	Yes
43. Sexual Assault Services			
	Network Depending upon where the Covered Health Care Service is		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	provided, Benefits will be the same as those stated under <i>Emergency Health Care Services - Outpatient, Hospital – Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient, Mental Health Care and Substance-Related and Addictive Disorders Services, Physician's Office Services - Sickness and Injury, and/or Urgent Care Center Services</i> in this <i>Schedule of Benefits</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Emergency Health Care Services - Outpatient, Hospital – Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient, Mental Health Care and Substance-Related and Addictive Disorders Services, Physician's Office Services - Sickness and Injury, and/or Urgent Care Center Services</i> in this <i>Schedule of Benefits</i> .		
44. Telemedicine Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay, Mental Health Care and Substance-Related and Addictive Disorders Services, Physician's Office Services - Sickness and Injury, Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, and/or Urgent Care Center Services</i> in this <i>Schedule of Benefits</i> .		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under <i>Hospital – Inpatient Stay, Mental Health Care and Substance-Related and Addictive Disorders Services, Physician's Office Services - Sickness and Injury, Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, and/or Urgent Care Center Services</i> in this <i>Schedule of Benefits</i> .		

Allowed Amounts

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

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

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

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

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment, or any deductible. Under such circumstances you will not be responsible for amounts you may be billed in excess of your cost sharing obligations.

Out-of-Network Benefits

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

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs

arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, and for non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*. Please see the complete notice, "Your Rights and Protections Against Surprise Medical Bills and Balance Billing", at <https://www.uhc.com/legal/required-state-notice/washington>.

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

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*. Please see the complete notice, "Your Rights and Protections Against Surprise Medical Bills and Balance Billing", at <https://www.uhc.com/legal/required-state-notice/washington>.

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

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency ground ambulance transportation provided by an out-of-Network provider**, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here..

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined, based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
 - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - ♦ 50% of *CMS* for the same or similar freestanding laboratory service.
 - ♦ 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
 - ♦ 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
 - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ♦ For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale 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 50% of the provider's billed charge.

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

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the *Public Service Act*.

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

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

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

Continuity of Care

Continuity of care is a feature of the Policy under which a Covered Person who is receiving care from an individual Network provider is entitled to continue with care with the individual Network provider for a limited period of time after the Network provider is no longer contracted with us to provide Covered Health Services.

You are entitled to continuity of care at the Network Benefit level as described above if all of the following apply:

- The written agreement for an individual provider has terminated.
- The provider no longer participates in the provider Network.
- The provider agrees to the same terms and conditions as those in the written agreement that has been terminated, except for any contractual provision requiring that the insurer assign new members to the terminated provider.

You may verify your continuity of care coverage by calling the telephone number on your ID card for Customer Care.

You are entitled to continuity of care when you are undergoing a course of treatment that is medically necessary and when both you and the provider agree that it is desirable to maintain continuity of care.

You are not entitled to continuity of care when the written agreement between the individual provider and us ends as a result of one of the following circumstances:

- The written agreement between the individual provider and us has ended because of any of the following:
 - The individual provider has retired.

- The individual provider has died.
- The individual provider no longer holds an active license.
- The individual provider has gone on sabbatical.
- The individual provider is prevented from continuing to care for patients because of other circumstances.
- The written agreement has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

We are not required to provide continuity of care if your coverage under the Policy ends or if the Enrolling Group discontinues the plan under which you are covered.

A Covered Person who is entitled to continuity of care shall receive the care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the Covered Person to continuity of care is completed.
- The 60th day after the date we notify you of the termination of the written agreement with the individual provider, or until the end of the next open enrollment period, if applicable.

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. If your care is coordinated through an Out-of-Network provider for this reason, Covered Health Care Services will be provided to you at no greater cost than if the service were obtained from a Network provider or facility, including your level of Co-payment and Co-insurance. Payments made for these Covered Health Care Services will be included in determining your responsibility under the Annual Deductible requirements for your plan.

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.

Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician of the member's choice. The Physician or specialist acting within his or her scope of practice, must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion.

One Pass Select Rider

UnitedHealthcare of Washington, Inc.

This Rider to the Policy is issued to the Group and provides a description of the One Pass Select program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Washington, Inc. When we use the words "you" and "your" we are referring to Covered Persons age 18 and older.

One Pass Select

One Pass Select provides a discounted fitness membership that is available for purchase. One Pass Select allows you to select a network of fitness facilities based on price, fitness-facility type, and location preferences. The four tiers listed below offer you the ability to utilize multiple locations at no additional cost per month.

Membership choices include:

Membership Tiers	Costs	Descriptions
Classic	\$29/month	10,000 fitness facilities.
Standard	\$64/month	12,000 fitness facilities.
Premium	\$99/month	14,000 fitness facilities.
Elite	\$144/month	15,000 fitness facilities.

You may access the One Pass Select program through www.myuhc.com or our mobile UnitedHealthcare app.

UnitedHealthcare of Washington, Inc.



Gary Daniels, President

Real Appeal Rider

UnitedHealthcare of Washington, Inc.

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.



Gary Daniels, President

UnitedHealthcare Rewards Rider

UnitedHealthcare of Washington, Inc.

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Washington, Inc. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain criteria, as described below. You may choose to complete any, or all, of the below criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health Reimbursement Account (HRA)* or *Health Savings Account (HSA)* or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 steps per day	You can earn rewards for one or multiple activity markers. You can earn additional rewards for participating in the Premium Program which provides additional activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Actions and/or Activities	One or more actions and/or activities defined by us and aimed at the following: • Health education; • Improving health;	

Activity Marker	Activity Target	Reward
	• Maintaining health; or • Administrative objectives	

You may access your actions and/or activity tracking and rewards on the mobile application or www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to a *Health Reimbursement Account (HRA)* or a *Health Savings Account (HSA)* or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.



Gary Daniels, President

Outpatient Prescription Drug Rider

UnitedHealthcare of Washington, Inc.

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 of Washington, Inc. 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*.



Gary Daniels, 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.

Coverage also includes Prescription Drug Products which have not yet been approved by the *Food and Drug Administration* for a particular indication, if the prescribed drug has been recognized as safe and effective for treatment of a particular indication in or by one or more of the following:

- In one of the following standard reference compendia:
 - ♦ *The American Hospital Formulary Service Drug Information.*
 - ♦ *The American Medical Association Drug Evaluation.*
 - ♦ *The United States Pharmacopoeia Drug Information.*
 - ♦ Other authoritative compendia as identified from time to time by the *Federal Secretary of Health and Human Services* or the insurance commissioner.
- In the majority of relevant peer reviewed medical literature if not recognized in one of the standard reference compendia.
- By the *Federal Secretary of Health and Human Services.*

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen no more than quarterly. These changes may not happen without a prior sixty-day notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement and to view the prescription drug list.

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, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product. You may determine if a pharmacy is a Designated Pharmacy by contacting us at www.myuhc.com or at the telephone number on your ID card.

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.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for 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.

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.

Medication Refill Synchronization

If you request medication synchronization for a new prescription drug, the plan will permit dispensing of the prescription if the following apply:

- For less than a one-month supply of the drug if synchronization will require more than a 15-day supply of the drug; or
- For more than a one-month supply of the drug if synchronization will require a 15-day supply of the drug or less.

The applicable Co-payment/Co-insurance will be adjusted for a prescription drug product that is dispensed for less than the standard refill amount for the purpose of synchronizing the medications by:

- Discounting the Co-payment rate by fifty percent;
- Discounting the Co-payment rate based on fifteen-day increments; or
- Any other method that meets the intent of the medication synchronization.

Upon request of medication synchronization, the Provider or pharmacist will determine if dispensing or refilling the prescription drug is in the best interest of the Covered Person, inform the Covered Person that the prescription drug product will be dispensed at less than the standard refill amount for the purpose of synchronizing his or her medications; and deny synchronization if there is threat to the patient's safety or if fraud or abuse is suspected.

For the purposes of this benefit, "medication synchronization" means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

Prescription Drug Products Substitution Process

You and your provider may request a substitution for a covered prescribed therapy, drug or medication of a covered generic or formulary drug if:

- You do not tolerate the covered generic or formulary drug;
- If your provider determines that the covered generic or formulary drug is not therapeutically effective; or
- If your provider determines that the dosage required for clinically effective treatment differs from our formulary dosage limitation.

We may require the provider to submit specific clinical documentation as part of the substitution request. Please call us at the telephone number on your ID card to request a substitution.

Benefits for Early Refills for Prescription Eye Drops

Benefits include one early refill of prescription eye drops, by a pharmacist, without consulting a physician or obtaining a new prescription or refill authorization, when the following criteria are met:

- The refill is requested by a Covered Person at or after seventy percent of the predicted days of use, from:
 - The date the original prescription was dispensed to the Covered Person; or
 - The date that the last refill of the prescription was dispensed to the Covered Person.
- The provider indicates on the original prescription that a specific number of refills will be needed.
- The refill does not exceed the number of refills that the provider indicated on the original prescription.

Benefits for Emergency Fill of a Prescription Drug Product

Benefits for an emergency fill of a Prescription Drug Product include no more than the prescribed amount, up to a seven (7) day emergency supply or the minimum packaging size available at the time of the emergency fill of a Prescription Drug Product, when the following criteria apply:

- The dispensing Network Pharmacy cannot reach UnitedHealthcare's prior authorization pharmacy department by telephone because it is outside of UnitedHealthcare's business hours; or
- UnitedHealthcare's pharmacy department is available to respond to telephone calls from the Network Pharmacy regarding a covered Benefit, but UnitedHealthcare's pharmacy department is not able to reach the prescriber for a full consultation.
- Determination as to whether a subsequent fill of the Prescription Drug Product, is a covered Benefit, will be made as part of UnitedHealthcare's prior authorization process.
- You are responsible for paying the same Co-payment and/or Co-insurance that would apply to a 30-day supply of a Prescription Drug Product for an emergency fill. Please refer to the Benefit Information table in the *Outpatient Prescription Drug Schedule of Benefits* for the applicable Copayment and/or Co-insurance.

Please contact us at www.myuhc.com or at the telephone number on your ID card for a list of medications available for emergency fill.

Coverage of an emergency fill of a Prescription Drug Product is not required if the failure to comply is occasioned by any act of God, bankruptcy, act of government authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products	146
Section 2: Exclusions	147
Section 3: Defined Terms	150
Section 4: Your Right to Request an Exception for Contraceptives ..	154

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.

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.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. 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 certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic or convenience purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine 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. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.

17. Prescription Drug Products for tobacco cessation.
18. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non- *FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 2 3 4.)
20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. 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, but not longer than three months from their release. Such review and approval of new Prescription Drug Products and/or new dosage forms is not required for any drug prescribed to treat a covered indication as long as both of the following apply:
 - The drug has been approved by the *United States Food and Drug Administration* for at least one indication.
 - The drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature. The standard reference compendia are noted above under the exclusion for Experimental or Investigational or Unproven Services.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate as described below under Eosinophilic Gastrointestinal Disorder and Prescription Drug Products in *Section 3: Defined Terms*.
24. 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.
25. 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.
26. 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.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. Dental products, including but not limited to prescription fluoride topicals.
30. 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.

31. Diagnostic kits and products, including associated services.
32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

If the prescription order or refill for the higher tiered Prescription Drug Product is requested by your provider and it states "dispense as written" (DAW), the Ancillary Charge will not apply, if determined to be Medically Necessary through the prior authorization process.

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.

Eosinophilic Gastrointestinal Disorder Formula - Medically Necessary amino acid-based formula, also known as elemental formula, regardless of delivery method, when a licensed Physician or other health care provider with prescriptive authority:

- Diagnoses a patient with eosinophilic gastrointestinal associated disorder; and
- Orders and supervises the use of the elemental formula.

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.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

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. This period of time will not be longer than three months from the date of their release 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*.
- Certain 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*.

As required under Washington law, Benefits under this section include contraceptives drugs, devices, and other products, approved by the *FDA*, including over-the-counter methods of contraception and products, approved by the *FDA* (including spermicide and condoms, regardless of the gender or sexual orientation of the Covered Person and regardless if the use is for contraception or for the prevention of sexually transmitted infections). Please note that benefits for *FDA* approved over-the-counter contraceptives do not require a prescription order for coverage to apply.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time (no more than quarterly). You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Prescriptive oral agents for controlling blood sugar levels.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - visual reading and urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucagon and emergency kits; and
 - glucose meters, including continuous glucose monitors.
- Depo Provera and other injectable drugs used for contraception.
- Medically Necessary elemental formula for the treatment of Eosinophilic Gastrointestinal Disorder.
- Prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent -when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact us, UnitedHealthcare, at www.myuhc.com or at the telephone number on your ID card. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the *Washington State Office of Insurance Commissioner* at 1-800-562-6900 or at www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the *Washington State Department of Health* at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

Section 4: Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by us, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information please visit www.uhcprovider.com under the following path: Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act \$0 Cost-Share Preventive Medications Exemption Requests (Commercial Members).

Outpatient Prescription Drug

UnitedHealthcare of Washington, Inc.

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. You can locate a Network Pharmacy by contacting us at the telephone number on your ID card or you can access a directory of providers online at www.myuhc.com.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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.

After the initial 30-day supply, contraceptive drugs may be refilled for up to twelve-month cycles, at one time, when the prescriber writes the prescription as such. We may limit refills obtained in the last quarter

of a plan year if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year. All eligible contraceptives are covered at zero cost share to the member.

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. You may determine whether a particular Prescription Drug Product requires prior authorization and the duration of the authorization by contacting us at www.myuhc.com or the telephone number on your ID card. 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. You may determine whether a particular Prescription Drug Product requires prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card. **To obtain prior authorization, call the telephone number on your ID card.**

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. You may determine whether a particular Prescription Drug Product requires prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card. **To obtain prior authorization, call the telephone number on your ID card.**

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation 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.

Utilization Review

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. Our utilization review process timeframes are conducted in a timely manner appropriate to the severity of the patient's condition and the urgency of the need for treatment. We will make clinical review criteria available upon request to Network providers.

For prior authorizations submitted through an electronic prior authorization process, as designated by the carrier, the following timelines will apply:

- For electronic standard prior authorization requests, within three calendar days, excluding holidays, if the information provided is sufficient to make a determination. If the information provided is not sufficient to make a decision, we will request additional information within one calendar day of submission of the electronic prior authorization.
- For electronic expedited prior authorization requests, within one calendar day if the information provided contains the necessary information to make a decision. If the information provided is not sufficient to make a decision, we will request additional information within one calendar day of submission of the electronic prior authorization.

For prior authorization requests received through a process other than an electronic process, if the review request from the provider is not accompanied by all necessary information, we will notify the provider what additional information is needed and the deadline for its submission. Upon the receipt of all necessary information or the expiration of the deadline for providing information, we will review the request for determination within the following timelines:

For urgent care review requests:

- Must approve the request within forty-eight hours if the information provided is sufficient to approve the claim;
- Must deny the request within forty-eight hours if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or
- Within twenty-four hours, if the information provided is not sufficient to approve or deny the claim, we will request additional information from the provider in order to make the prior authorization determination. The provider has forty-eight hours to provide us with the additional information. Upon receipt of the additional information the request will be approved or denied within forty-eight hours.

For non-urgent care review requests:

- Must approve the request within five calendar days if the information provided is sufficient to approve the claim;
- Must deny the request within five calendar days if the requested service is not medically necessary and the information provided is sufficient to deny the claim; or
- Within five calendar days, if the information provided is not sufficient to approve or deny the claim, we will request additional information from the provider in order to make the prior authorization determination. The provider has five calendar days to provide us with the additional information. Upon receipt of the additional information the request will be approved or denied within four calendar days.

Notification of the Determination

We will provide the attending Physician, ordering provider, and Covered Person with written or electronic notification of our determination or you may call us at the telephone number on your ID card.

Whenever there is an adverse determination we will notify the ordering provider and the Covered Person in advance and indicate whether the notification will be provided by telephone, mail, fax, or other means. We will provide notice by electronic notification meeting the *United States Department of Labor* standards.

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

"Non-urgent review request" means any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services and is not an urgent care request.

"Urgent care review request" means any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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.

What Do You Pay?

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent.

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*:

- 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.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.

Payment Information

Payment Term And Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	\$5,000 per Covered Person.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. Co-insurance Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. Co-payment and Co-insurance Your Co-payment 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	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. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin, on any tier, will not exceed \$35 per prescription up to a 30-day supply, regardless of the type of insulin drug prescribed for that 30-day period, not subject to the deductible. For mail order, your Co-payment and/or Co-insurance for insulin, on any tier, will not exceed \$70 per prescription up to a 60-day supply and \$105 up to a 90-day supply, regardless of the type of insulin drug prescribed for that 60-day or 90-day period, not subject to the deductible. 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 from time to time. These changes happen no more than quarterly, 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.	

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
PPACA Zero Cost Share Preventive Care Medications	
PPACA Zero Cost Share Preventive Care Medications, as defined under <i>Section 3: Defined Terms</i> in the <i>Outpatient Prescription Drug Rider</i>, that are obtained at a Network Pharmacy or mail order 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 and/or Co-insurance). Please note that benefits for FDA approved over-the-counter contraceptives do not require a prescription order for coverage to apply. You may determine whether a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or at the telephone number on your ID card.	You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications, regardless of which tier the PPACA Zero Cost Share Preventive Care Medications are assigned to. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.
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. 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 or days the drug will be delivered. Supply limits apply to Specialty Prescription Drug	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, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. Network Pharmacy For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product:

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
Products obtained at a Network Pharmacy, an out-of-Network Pharmacy or a mail order Network Pharmacy.	None of the Prescription Drug Charge after you pay \$40 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$80 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill.
	<i>Out-of-Network Pharmacy</i> For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$40 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$80 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: 30% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: - As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. - Allows for up to a 12-month refill, after the initial 31-day fill, of all covered contraceptives, to be dispensed at one time when the prescriber writes the prescription	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, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$10 per

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 such. All eligible contraceptives are covered at \$0 cost share. As written by the provider, up to a 90-day supply of a Prescription Drug Product for payment of 3 times the retail Co-payment. 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 or days the drug will be delivered.	Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$80 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge 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 or, if desired for a first-time fill 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 receive up to 12-months' cycles 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 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 or days the drug will be delivered.	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, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay \$80 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 30% of the Out-of-Network Reimbursement Rate 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
Prescription Drug Products from a Mail Order 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. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. Allows for up to a 12-month refill, after the initial 31-day fill, of all covered contraceptives, to be dispensed at one time when the prescriber writes the prescription as such. All eligible contraceptives are covered at \$0 cost share. 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 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.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. 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, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$25 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$100 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$200 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 30% of the Prescription Drug Charge per Prescription Order or Refill.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could

cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

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

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 30 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

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

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024:

We² are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health

information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 2. Biometric Information

3. Child or Adult Abuse or Neglect, including Sexual Assault
4. Communicable Diseases
5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

²This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY),

Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc. UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024:

We³ are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-445-9090.

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：1-800-445-9090。

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 1-800-445-9090.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-445-9090 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-445-9090.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является Русский (Russian). Позвоните по номеру 1-800-445-9090.

1-800-445-9090)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ Arabic (Arabic): إذا كنت تتحدث العربية

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-445-9090.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-445-9090.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-445-9090.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-445-9090.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-445-9090.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-445-9090 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。1-800-445-9090 (お電話ください)。

(Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. توجه: اگر زبان شما فارسی تماس بگیرید. 1-800-445-9090

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-445-9090

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-445-9090.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-445-9090 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-800-445-9090.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíí'k'eh, bee ná'ahóót'i'. T'áá shoodí kohjì 1-800-445-9090 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-445-9090.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-445-9090.

બાન અપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો અપને ભાષાકીય મદદરૂપ સેવા વિનં મૂલ્ય પ્રાપ્ય છે.
ફૂપા કરી 1-800-445-9090 પર કોલ કરો. TTY 711

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

¹For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.