UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan CTXP

of

Pacific Bath

Group Number: 933597

Effective Date: January 1, 2024

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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 that are 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*.

Individuals have direct access to OB/GYN and other health care providers without a referral or authorization requirement for Covered Health Care Services.

The Enrolled Dependent child(ren) have direct access to a physician who specializes in pediatrics without a referral or authorization for Covered Health Care Services.

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

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

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

Does Prior Authorization Apply?

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

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have

obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

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

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

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

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

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

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

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

Please note: The Prior Authorization requirements do not apply to you when you are enrolled in Medicare on a primary basis.

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.

Covered Preventive Care Services

The following services are preventive services as recommended by the *United States Preventive Task Force*. These preventive services are covered at no cost share to the Covered Person. These services may also be located online at http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. You may view women's preventive services at http://www.hrsa.gov/womensguidelines/. If you do not have internet access, please call us at the telephone number on your ID card. The following listed preventive care services are subject to change to coincide with federal government changes, updates, and revisions:

- Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;
- Aspirin Use to Prevent Cardiovascular Disease (CVD) and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10% or greater 10-year CVD risk;
- Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia;
- Asymptomatic Bacteriuria screening: pregnant persons;
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with BRCA1/2 gene mutation;
- Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older;
- Breast Cancer: Screening: women aged 50 to 74 years;
- Breastfeeding Primary Care Interventions: pregnant women, new mothers, and their children;
- Cervical Cancer: Screening women aged 21 to 65 years;
- Chlamydia and Gonorrhea Screening: sexually active women, including pregnant persons;
- Colorectal Cancer: Screening: adults aged 45 to 49 years;
- Colorectal Cancer: Screening: adults aged 50 to 75 years;
- Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
- Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
- Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;
- Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
- Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy;
- Gestational Diabetes; Screening: asymptomatic pregnant women, at 24 weeks of gestation or after;
- Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling: adults with CVD risk factors;
- Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: pregnant persons;
- Hepatitis B Virus Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection;
- Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;

- Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
- Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
- Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
- Hypertension in Adults: Screening: adults aged 18 years or older without known hypertension;
- Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
- Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
- Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication: pregnant women who are at high risk for preeclampsia;
- Lung Cancer Screening: adults aged 50 - 80 who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years;
- Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
- Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
- Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
- Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
- Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who are overweight or obese;
- Preeclampsia: Screening: pregnant women;
- Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of HIV acquisition;
- Rh(D) Incompatibility: Screening: unsensitized Rh(D)-negative pregnant women;
- Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
- Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk;
- Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children and parents of young children;
- Statin Use for the Primary Prevention of Cardiovascular Disease (CVD) in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors, and an estimated 10-year CVD event risk of 10% or greater;
- Syphilis Infection in Nonpregnant Adults and Adolescents: Screening: asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
- Syphilis Infection in Pregnant Women: Screening: pregnant women;
- Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
- Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Behavioral and Pharmacotherapy Interventions: pregnant women;

- Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
- Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
- Unhealthy Drug Use: Screening: adults age 18 years or older;
- Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years; and
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults;

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. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your 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 *Schedule of Benefits* table.	***Network*** $500 per Covered Person, not to exceed $1,000 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-	***Network*** $4,500 per Covered Person, not to

Payment Term And Description	Amounts
Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, 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. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	exceed $9,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $9,000 per Covered Person, not to exceed $18,000 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 *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of 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?**
1. Acupuncture Services			
Limited to 12 treatments per year.	***Network*** $25 per visit ***Out-of-Network*** Same as Network	Yes Same as Network	No Same as Network
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.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 20% *Air Ambulance* 20% ***Out-of-Network*** Same as Network	Yes Yes Same as Network	Yes Yes Same as Network
Non-emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance	***Network*** *Ground Ambulance* 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 *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?**
transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Air Ambulance* 20% ***Out-of-Network*** *Ground Ambulance* Same as Network *Air Ambulance* Same as Network	 Yes Same as Network Same as Network	 Yes Same as Network Same as Network
3. Autism Spectrum Disorder Services - Behavioral Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Autism Spectrum Disorder Services - Behavioral 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. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).* If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
This Benefit is subject to the *Mental Health Parity and Addiction Equity Act (MHPAEA)* law. Benefit levels must be comparable and limitations no more restrictive than other medical	***Network*** *Inpatient* 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 *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?**
Benefits. This Benefit is subject to the *Mental Health Parity and Addiction Equity Act (MHPAEA)* law. Benefit levels must be comparable and limitations no more restrictive than other medical Benefits.	*Outpatient* $25 er visit 20% for Partial Hospitalization/Intensive Outpatient Treatment ***Out-of-Network*** *Inpatient* 40% *Outpatient* 40% 40% for Partial Hospitalization/Intensive Outpatient Treatment	 Yes Yes Yes Yes Yes	 No Yes Yes Yes Yes
4. Behavioral Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Behavioral Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*			

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?**
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.			
This Benefit is subject to the *Mental Health Parity and Addiction Equity Act (MHPAEA)* law. Benefit levels must be comparable and limitations no more restrictive than other medical Benefits.	***Network*** *Inpatient* 20% *Outpatient* $25 per visit 20% for Partial Hospitalization/Intensive Outpatient Treatment	 Yes Yes Yes	 Yes No Yes
This Benefit is subject to the *Mental Health Parity and Addiction Equity Act (MHPAEA)* law. Benefit levels must be comparable and limitations no more restrictive than other medical Benefits.	***Out-of-Network*** *Inpatient* 40% *Outpatient* 40% 40% for Partial Hospitalization/Intensive Outpatient Treatment	 Yes Yes Yes	 Yes Yes Yes
5. Cellular and Gene Therapy			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Pharmaceutical Products - Outpatient; Physician*		

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?**
	Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury and/or *Surgery - Outpatient* in this *Schedule of Benefits*. ***Out-of-Network*** Out-of-Network Benefits are not available.		
6. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatient* in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatient* in this *Schedule of Benefits*.		
7. Congenital Heart Disease (CHD) Surgeries			
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			

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?**
outcomes for 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 *Schedule of Benefits*.	***Network*** 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
8. Dental Services - Accident Only			
Services are covered when treatment is necessary because of accidental damage when dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry, and the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***Network*** 20% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
9. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			

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?**
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care **Diabetes Self-Management Items** Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Durable Medical Equipment (DME)* and/or *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits*. and in the *Outpatient Prescription Drug Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Durable Medical Equipment (DME)* and/or *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits*. and in the *Outpatient Prescription Drug Schedule of Benefits*. ***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*.		
10. Durable Medical Equipment (DME), Orthotics and Supplies			
Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or	***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 *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?**
replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician. The limits above do not apply to orthotics that are covered under *DME*.	***Out-of-Network*** Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.	Out-of-Network Benefits are not available.
11. 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	***Network*** 20% after you pay $300 per visit.	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
Care Service. If you are admitted as an inpatient to a Hospital directly from the emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Out-of-Network*** Same as Network	Same as Network	Same as Network
12. Enteral Nutrition			
	Network 20%	Yes	Yes
	Out-of-Network 40%	Yes	Yes
13. 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	***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 *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?
coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under *Preimplantation Genetic Testing (PGT) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	***Out-of-Network*** 40%	Yes	Yes
14. Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

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

It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under *Behavioral Health Care and Substance-Related and Addictive Disorders Services; Durable Medical Equipment (DME), Orthotics and Supplies, Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient*; and/or *Prosthetic Devices* in this *Schedule of Benefits*.

	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under

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?**
	Behavioral Health Care and Substance-Related and Addictive Disorders Services; Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; 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 *Behavioral Health Care and Substance-Related and Addictive Disorders Services; Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; 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*.		
15. 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	***Network*** *Inpatient*		

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?**
combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*. These visit limits are subject to medical necessity and will not apply to *Autism Spectrum Disorder Services - Behavioral Services* or *Behavioral Health Care and Substance-Related and Addictive Disorders Services*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* in this *Schedule of Benefits.*		
Outpatient therapies: • Physical therapy. • Occupational therapy. • 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.* These visit limits are subject to medical necessity and will not apply to *Autism Spectrum Disorder Services - Behavioral Services* or *Behavioral Health Care and Substance-Related and Addictive Disorders Services*.	*Outpatient* $25 per visit	Yes	No
	Out-of-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 Facility*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
	Services in this *Schedule of Benefits.*		
	Outpatient 40%	Yes	Yes
16. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every three years (or more frequently if modifications to an existing hearing aid will not meet the needs of a Covered Person). Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Coverage includes up to one box of replacement batteries per year for each hearing aid.	***Network*** 20%	Yes	Yes
	Out-of-Network 40%	Yes	Yes
17. 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.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of Intravenous infusion	***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 *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?**
you must receive services from a provider we identify. Services are covered when received from a Home Health Agency that are ordered by a Physician and provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.	***Out-of-Network*** 40%	Yes	Yes
18. 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 20%	Yes	Yes
	Out-of-Network 40%	Yes	Yes
19. 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.			

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?**
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 20% ***Out-of-Network*** 40%	 Yes Yes	 Yes Yes
20. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	***Network*** 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 20% ***Out-of-Network*** 40%	 Yes Yes	 Yes Yes
21. 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.			

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?**
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 20% ***Out-of-Network*** 40%	 Yes Yes	 Yes Yes
22. Ostomy Supplies			
	Network 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.	 Yes Out-of-Network Benefits are not available.
23. Pharmaceutical Products - Outpatient			
Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable Co-payment and/or Co-insurance.	***Network*** 20% ***Out-of-Network*** 40%	 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 *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?**
24. Physician Fees for Surgical and Medical Services			
Allowed Amounts for 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 *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
25. 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 in the *Certificate of Coverage* under Major *Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described in the *Certificate of Coverage* under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described in	***Network*** $25 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
the *Certificate of Coverage* under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described in the *Certificate of Coverage* under *Surgery - Outpatient*. • Outpatient therapeutic procedures described in the *Certificate of Coverage* under *Therapeutic Treatments - Outpatient*. Benefits for services provided by a Naturopathic Physician are included.	***Out-of-Network*** 40%	Yes	Yes
26. 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.			
Benefits for Medically Necessary treatments for a woman to manage her maternal diabetes from conception through six weeks post-partum, cannot be subject to Co-payments, Co-insurance, or Annual Deductibles. This applies to both Network and Out-of-Network services. Coverage may be limited by network	***Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Scopic Procedures - Outpatient Diagnostic and Therapeutic;* and/or *Surgery - Outpatient* in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child		

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?**
and formulary restrictions that apply to other Benefits under the Policy, and does not apply to services, medications, test strips and syringes that are not covered due to the network or formulary restrictions. The Covered Person or the Covered Person's health care provider may be required to seek prior authorization	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 *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Scopic Procedures - Outpatient Diagnostic and Therapeutic;* and/or *Surgery - Outpatient* in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
27. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.	***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 *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?**
This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.	***Out-of-Network*** 40%	Yes	Yes
28. 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.
29. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices			

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?**
that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Network*** 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
30. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatien*t in this *Schedule of Benefits*. ***Out-of-Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatien*t in this *Schedule of Benefits*.		
31. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. These visit limits are subject to medical necessity and will not apply to *Autism Spectrum Disorder Services - Behavioral Services* or *Behavioral Health Care and Substance-Related and Addictive Disorders Services*. An additional 30 visits for severe neurologic conditions may be	***Network*** $25 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
available when Medically Necessary.	***Out-of-Network*** 40%	Yes	Yes
32. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to 60 days per year.	***Network*** 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
34. Spinal Manipulative Treatment Services			
Benefits are limited 20 Spinal Manipulative Treatment Services.	***Network*** $25 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
	Out-of-Network Same as Network	Same as Network	Same as Network
35. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 20% ***Out-of-Network*** 40%	Yes Yes	Yes Yes
36. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: 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.			
Examples of Covered Health Care Services include dialysis (both hemodialysis and peritoneal dialysis),	***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?**
intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.	20% ***Out-of-Network*** 40% For dialysis services, Out-of-Network Benefits are not available.	Yes Yes For dialysis services, Out-of-Network Benefits are not available.	Yes Yes For dialysis services, Out-of-Network Benefits are not available.
37. Transplantation Services			
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. For additional details please see Designated Providers for Transplantation Services in this *Schedule of Benefits*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatient* in this *Schedule of Benefits.* ***Out-of-Network*** Out-of-Network Benefits are not available.		
38. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described in the Certificate of Coverage under	***Network*** $50 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
Major Diagnostic and Imaging - Outpatient. • Outpatient Pharmaceutical Products described in the Certificate of Coverage under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described in the Certificate of Coverage under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described in the Certificate of Coverage under *Surgery - Outpatient*. • Outpatient therapeutic procedures described in the Certificate of Coverage under *Therapeutic Treatments - Outpatient*.	***Out-of-Network*** 40%	Yes	Yes
39. Urinary Catheters			
	Network 20% ***Out-of-Network*** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	Yes 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 *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?**
Additional Benefits Required By Oregon Law			
40. Autism Spectrum Disorder - Medical Services			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
Treatment for Autism Spectrum Disorder - Medical Services is considered a behavioral health benefit. Such treatment encompasses problems associated with Autism Spectrum Disorder - Medical Services for which rehabilitative or habilitative services would be appropriate for Covered Persons. An additional 30 visits for severe neurologic conditions may be available when Medically Necessary. These visits limits are subject to medical necessity and will not apply to *Autism Spectrum Disorder Services - Behavioral Services* or *Behavioral Health Care and Substance-Related and Addictive Disorders Services*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Autism Spectrum Disorder Services - Behavioral Services, Behavioral Health Care and Substance-Related and Addictive Disorders Services; Durable Medical Equipment (DME), Orthotics and Supplies, Habilitative Services, Physician's Office Services - Sickness and Injury, Rehabilitation Services - Outpatient Therapy,* and/or *Skilled Nursing Facility/Inpatient Rehabilitation Facility Service*s in this *Schedule of Benefits* and/or *Outpatient Prescription Drug Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Autism Spectrum Disorder Services - Behavioral Services, Behavioral Health Care and Substance-Related and Addictive Disorders Services; Durable Medical Equipment (DME), Orthotics and Supplies, Habilitative Services, Physician's Office Services - Sickness and Injury, Rehabilitation Services -*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
	Outpatient Therapy, and/or *Skilled Nursing Facility/Inpatient Rehabilitation Facility Service*s in this *Schedule of Benefits* and/or *Outpatient Prescription Drug Schedule of Benefits*.		
41. Cochlear Implants			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Services 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; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatient* in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Services 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; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury* and/or *Surgery - Outpatient* in this *Schedule of Benefits*.		
42. Hearing Assistive Technology Systems and Bone Conduction Sound Processors			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining Hearing Assistive Technology Systems and Bone Conduction Sound Processors. If you fail to obtain prior authorization			

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?**
as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefits are available for hearing assistive technology systems for a Covered Person who is younger than 19 years of age, if necessary for appropriate amplification of hearing loss. Benefits are limited to a single purchase every three years.	***Network*** 20% ***Out-of-Network*** 40%	 Yes Yes	 Yes Yes
43. Hearing Loss Diagnostic and Treatment Services			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
Benefits are available for necessary diagnostic and treatment services at least twice a year for Covered Persons who are younger than four years of age and at least once per year for Covered Persons who are four years of age or older.	***Network*** Depending upon where the Covered Health Care Services is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostic - Outpatient; Physician's Office Services - Sickness and Injury* and/or *Therapeutic Treatments - Outpatient* in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Services is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostic - Outpatient; Physician's Office Services - Sickness and Injury* and/or *Therapeutic Treatments - Outpatient* in this *Schedule of Benefits*.		
44. Oregon Universal Newborn			

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?**
Nurse Home Visiting Program			
Prior Authorization Requirement For Out-of-Network Benefits, 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.			
Benefit coverage will be provided by registered nurses licensed in this state to families caring for Dependent newborns up to the age of six months. Covered Health Care Services are offered to all families with newborns residing in the community where the program operates and must include: • At least one visit during a newborn's first three months of life with the opportunity for the family to choose up to three additional visits.	***Network*** None ***Out-of-Network*** 40%	Yes Yes	No Yes
45. Telemedical Services			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
Covered Telemedicine Health Care Services may be available from On-Demand National Providers. These On-Demand National Providers are able to provide telemedicine services received outside of a medical facility (for example, from home or from	***Network*** *On-Demand National Providers* 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 *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?**
work) for the diagnosis and treatment of less serious medical conditions. Covered Health Care Services including urgent on-demand care can also be provided from providers who are not On-Demand National Providers. "Telemedical" means delivered using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf. For additional details please see Telemedical Services under *Section 1: Covered Health Care Services* in the *Certificate of Coverage*.			
	All Other Network Providers Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Autism Spectrum Disorder Services - Behavioral Services, Autism Spectrum Disorder - Medical Services, Behavioral Health Care and Substance-Related and Addictive Disorders Services; Diabetes Services/Supplies, Durable Medical Equipment (DME), Orthotics and Supplies, Habilitative Services, Hospital - Inpatient Stay, Physician's Office Services - Sickness and Injury, Rehabilitation Services - Outpatient Therapy* and/or *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* in this *Schedule of Benefits*. ***Out-of-Network***		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Autism Spectrum Disorder Services - Behavioral Services, Autism Spectrum Disorder - Medical Services, Behavioral Health Care and Substance-Related and Addictive Disorders Services; Diabetes Services/Supplies, Durable Medical Equipment (DME), Orthotics and Supplies, Habilitative Services, Hospital - Inpatient Stay, Physician's Office Services - Sickness and Injury, Rehabilitation Services - Outpatient Therapy* and/or *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services* in this *Schedule of Benefits*.		
46. Tobacco Use Cessation			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits* and/or *Outpatient Prescription Drug Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits* and/or *Outpatient Prescription Drug Schedule of Benefits*.		
47. Voluntary Sterilization Procedures for Men and Termination of Pregnancy			
Prior Authorization Requirement			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts 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?**
For Out-of-Network Benefits, 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 None	Yes	No
	Out-of-Network 40%	Yes	Yes

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

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

Out-of-Network Benefits

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

- **For non-emergency Covered Health Care Services received at 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 Health Service Ac*t with respect to a visit as defined by the Secretary, 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, 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*.
- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.

- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*

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

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

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

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

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related

companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service
- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

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

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for

specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

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 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 Care Services to Covered Persons.

You are entitled to continuity of care 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.
- We do not cover services when services are provided to Covered Persons by the individual provider or we cover services at a Benefit level below the Benefit level specified in the Policy for out-of-Network providers.
- In order to obtain continuity of care, you must request continuity of care by calling us at the telephone number on your ID card.
- 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 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 contract 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 Group discontinues the plan under which you are covered.
    - Except as provided for Pregnancy described below, 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 120th day after the date we notify you of the termination of the written agreement with the individual provider.
- A Covered Person who is undergoing care for Pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the Pregnancy shall receive the care until the later of the following dates:
- The 45th day after the birth.
- As long as the Covered Person continues under an active course of treatment, but not later than the 120th day after the date we notify you of the termination of the written agreement with the individual provider.

Designated Providers for Transplantation Services

If you have a medical condition that requires transplantation, we will refer you to the Designated Provider most suitable to treat your condition. If you require certain complex Covered Health Care Services for transplantation 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 transplantation 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.

Limitations on Selection of Providers

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

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

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

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

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

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

Can This Certificate Change?

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

Other Information You Should Have

We may change, withdraw or add Benefits, or end the Policy, at the time of renewal or as permitted by state law. We will provide you with advance written notice, when we change, or withdraw or add Benefits, or end the Policy.

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. 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 by calling 1-800-624-8822. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

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

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

Your Group may require you to pay your share of any required Premium 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. Examples of the portion of the cost that you may be responsible for paying are Co-payments, Co-insurance and Annual Deductibles.

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 our Network. The Subscriber may designate any willing Network pediatrician as his/her child's Primary Care Physician. Women may designate a woman's health care provider as her Primary Care Physician. 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.

Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:

- Prior authorization determinations relating to Benefit coverage and medical necessity shall be binding on us if obtained no more than 30 days prior to the date the service is provided.
- Prior authorization determinations relating to Enrollee eligibility shall be binding on us if obtained no more than five business days prior to the date the service is provided.

For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance and/or Annual Deductible 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, Co-insurance and Annual Deductible amounts are listed in the *Schedule of Benefits*.

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 so that the provider can identify that you are covered under a UnitedHealthcare Policy. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

Out-of-Network Services - File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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 coverage ends as described in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Behavioral Health Condition, 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.

Please review the *Schedule of Benefits* and prior authorization requirements before seeking treatments.

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 following conditions:

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

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

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

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

2. Ambulance Services

Emergency 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. Oregon law requires that we pay ambulance care and transportation providers directly.

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

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

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

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

3. Autism Spectrum Disorder Services - Behavioral Services

Medically Necessary behavioral health care services for the treatment of a diagnosis of Autism Spectrum Disorder.

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Behavioral 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 or a licensed provider acting within the scope of his or her license; or
- Medically Necessary for treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes 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 as described under *Autism Spectrum Disorder - Medical Services* in this *Certificate*.

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

We encourage you to contact the Behavioral Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

The coverage provided in this *Certificate of Coverage* for *Autism Spectrum Disorder Services* is in compliance with federal mental health parity.

4. Behavioral Health Care and Substance-Related and Addictive Disorders Services

Behavioral Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure. Covered Health Care Services include treatment for Substance-Related and Addictive Disorders, and for behavioral health conditions. We cannot deny a court-ordered screening or treatment of a Covered Person who is convicted of driving under the influence of intoxicants.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

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

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

The coverage provided in this *Certificate* for *Behavioral Health Care and Substance-Related and Addictive Disorders Services* is in compliance with federal mental health parity.

5. 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*.

6. Clinical Trials

Coverage is provided for the routine costs of the care of patients enrolled in and participating in approved clinical trials.

"Routine costs" means Medically Necessary conventional care, items or services covered by the Health Benefit Plan if typically provided absent a clinical trial. "Routine costs" do not include:

- The drug, device or service being tested in the clinical trial unless the drug, device or service would be covered for that indication by the Health Benefit Plan if provided outside of a clinical trial;
- Items or services required solely for the provision of the drug device or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;
- Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial or;
- Items or services that are not covered by the health plan if provided outside of the clinical trial.

An "approved clinical trial" means a clinical trial that is:

- Funded by the *National Institutes of Health*, the *Centers for Disease Control and Prevention*, the *Agency for Healthcare Research and Quality*, the *Centers for Medicare and Medicaid Services*, the *United States Department of Defense* or the *United States Department of Veterans Affairs*;
- Supported by a center or cooperative group that is funded by the *National Institutes of Health*, the *Centers for Disease Control and Prevention*, the *Agency for Healthcare Research and Quality*, the *Centers for Medicare and Medicaid Services*, the *United States Department of Defense* or the *United States Department of Veterans Affairs*;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the *United States Food and Drug Administration*; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the *United States Food and Drug Administration*.

We may not exclude, limit or impose additional conditions on the coverage of the routine costs for items and services provided in connection with participation in an approved clinical trial.

We may not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

The Policy and *Certificate* complies with the federal clinical trials mandate.

A qualified individual is someone who is eligible to take part in an approved clinical trial and either the individual's doctor has concluded that the participation is appropriate or scientific information established that their participation is appropriate.

The *Affordable Care Act (ACA)* requires that if a "qualified individual" is in an "approved clinical trial", the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside the designated class of approved clinical trials, and plans may not deny coverage because a Covered Person is participating in an approved clinical trial takes place outside of the state in which the Covered Person lives.

A "qualified individual" is someone who is eligible to take part in an "approved clinical trial".

An "approved clinical trial" is defined as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or disease. (The Oregon mandate does not limit clinical trials to just these items.)

Expenses include routine patient costs which include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.

If a Participating Provider is participating in an approved clinical trial, the plan may require the individual to take part in the trial through that Participating Provider if the provider will accept the individual as a participant in the trial.

7. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

8. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

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

Benefits for treatment of accidental Injury are limited to the following:

- Emergency Medical Condition 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.

9. 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.

Covered Health Care Services for maternal diabetes management, including medications or supplies Medically Necessary for management of diabetes from conception through six weeks postpartum are covered without Co-payment, Co-insurance, or deductible. However, coverage may be limited by Network and formulary restrictions that apply to other Benefits under this Policy. Coverage does not apply to services, medications, test strips and syringes that are not covered due to the Network or formulary restrictions. The Covered Person or her health care provider may be required to seek prior authorization.

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 urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.

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

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount

that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

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

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

Benefits also include 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 and other rigid or semi-rigid devices (orthotics) that support a weak or deformed leg, foot, arm, hand, back or neck or that restrict or eliminate motion in a diseased or injured leg, foot, arm, hand, back or neck and braces to treat curvature of the spine are a Covered Health Care Service. Orthotics are those devices that are listed as covered services in the Medicare fee schedule for DME, prosthetics, orthotics and supplies, but only to the extent consistent with this section.

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

Benefits are available for repairs and replacement of orthotic devices which are determined by your Physician to be Medically Necessary in order to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience, 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*.

11. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment for an Emergency Medical Condition. Emergency Health Care Services must be received on an Outpatient basis at a Hospital or Alternate Facility. (See definition of Emergency Health Care Services and Behavioral Health Assessment in *Section 9: Defined Terms*.)

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).

If you believe that you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest Hospital or Alternate Facility for treatment. You do not need to obtain prior authorization to seek treatment for an Emergency Health Care Service. Emergency Health Care Services received from a non-Participating Provider will be covered:

- Without any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to Participating Providers;
- Without a Co-payment amount or Co-insurance rate that exceeds the amount or rate for Participating Providers;
- Without a deductible, unless the deductible applies generally to non-Participating Providers; and
- Subject only to an Out-of-Pocket Limit that applies to all services from non-Participating Providers.

12. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding, for certain conditions including inborn errors of metabolism, under the direction of a Physician.

13. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

14. 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. We do not exclude or deny Benefits for Covered Health Care Services 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 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*.

15. Habilitative Services

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

Habilitative services are limited to:

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

Habilitation services must be performed by a licensed health care professional, as long as the services performed are within the licensed health care professional's scope of practice and are commensurate with the licensed health care professional's post-secondary education, training and supervised experience including a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist, a licensed behavior analyst or assistant behavior analyst or autism technician licensed under the laws of the state of Oregon to perform the specific service commensurate with the licensed health care professional's post-secondary education, training and supervised experience.

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

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

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.

  NOTE: Residential Treatment services are covered under *Autism Spectrum Disorder Services - Behavioral*, and *Behavioral Health Care and Substance-Related and Addictive Disorders Services* when Medically Necessary.
- 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.*

Other than as described under Habilitative Services above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. We will pay Benefits for Medically Necessary physical therapy, speech therapy, and occupational therapy following a traumatic brain injury.

16. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). "Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except cords.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing. Benefits include coverage of ear molds and replacement ear molds, and batteries.

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

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

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

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

Please contact us at the telephone number shown on your ID card for specific coverage requirements.

17. Home Health Care

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

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

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

18. 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's primary caregiver.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

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

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

19. Hospital - Inpatient Stay

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

Benefits are available for:

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

20. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Benefits for screening or diagnostic purposes include:
    - A mammogram in symptomatic or high-risk individuals at any time upon referral of the individual's health care provider.

- A mammogram every year for individuals age 40 and over, with or without referral from the individual's health care provider.

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*.

Sleep studies are covered when ordered by a pulmonologist, neurologist, otolaryngologist or certified sleep medicine specialist and when performed at a certified sleep laboratory.

21. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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*.)

22. Ostomy Supplies

Benefits for ostomy supplies are those supplies that are listed as covered services in the Medicare fee schedule for durable medical equipment, prosthetics, orthotics and supplies, not only to the extent consistent with this section.

23. 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.

Since 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 (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.* If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we may direct you to a Specified Dispensing Entity. Specialty Pharmaceutical Products are those drugs that are typically self-administered and include, but are not limited to such drugs as: Synagis, botulinum toxic products, Xolair and certain hyaluronic acid products. Such Specified Dispensing Entities may include an Outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

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.

24. 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.

25. Physician's Office Services - Sickness and Injury

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

Covered Health Care Services include child abuse medical assessments.

"Child abuse medical assessment" means an assessment by or under the direction of a licensed Physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. "Child abuse medical assessment" includes the taking of a thorough medical history, a complete physical exam and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child.

A Health Benefit Plan shall provide payment to or reimburse a community assessment center for the services provided by the center:

- In conducting a child abuse medical assessment of a child enrolled in the plan and that are related to the child abuse medical assessment including, but not limited to:
    - A forensic interview; and
    - Behavioral health treatment.

The payment or reimbursement made in accordance with this section must be proportionate to the scope and intensity of the services provided by the community assessment center.

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

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

Covered Health Care Services include Genetic Counseling.

Benefits include allergy testing and injections.

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

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

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

26. Pregnancy - Maternity Services

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

Covered Health Care Services for maternal diabetes management, including medications or supplies Medically Necessary for management of diabetes from conception through six weeks postpartum are covered without Co-payment, Co-insurance or deductible. However, coverage may be limited by Network and formulary restrictions that apply to other Benefits under the Policy. Coverage does not apply to services, medications, test strips and syringes that are not covered due to the Network or formulary restrictions. The Covered Person or health care provider may be required to seek prior authorization.

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

We 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.

27. 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).

28. 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 (USPSTF)* including all colorectal cancer screening exams and laboratory tests for Covered Persons 50 years old or older as recommended by the treating Physician, including fecal occult blood tests, colonoscopies and the removal of polyps during a screening procedure or double contract barium enemas.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including the Human Papilloma Virus (HPV) vaccine.
- 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 individuals, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including breast cancer screening, and all *Federal Drug Administration (FDA)* approved contraceptive methods.

  Screening mammography to include:

  - A mammogram in symptomatic of high-risk individual at any time upon referral of the individual's health care provider.
  - A mammogram every year for individuals age 40 and over, with or without referral from the individual's health care provider.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include but may be limited to the full range of *FDA* approved contraceptive methods without cost sharing. Benefits include at least one form of contraception in each of the methods (currently 18) that the *FDA* has identified in its Birth Control Guide. These methods are including but not limited to hormonal methods including oral contraceptives, patches or injectables (self-administered and/or provider administered), barrier methods such as prescription diaphragms and implanted devices and oral medications for emergency contraception.

  Pelvic and Pap smear exams as follows:

  - Annually for individuals 18 to 64 years of age; and
  - At any time upon referral of the individual's health care provider.

  Covered breast cancer screening services also include a complete and thorough physical exam of the breast, including but not limited to a clinical breast exam performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

  - Annually for individuals 18 years of age and older; and
  - At any time at the recommendation of the individual's health care provider.

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

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

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

- Individuals may receive the following routine individual's services directly from a Participating Provider without a referral or prior authorization.
  - Medically Necessary obstetrical and gynecological services including routine prenatal obstetrical office visits.
  - Pelvic and Pap Smear Exams annually for individuals ages 18 to 64 without a referral, or at any time with a referral.
- With respect to men, prostate cancer screening.
- Covered preventive care services are no limited based on an individual's sex assignment at birth, gender identity, or recorded gender.

You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. You may view Women's Preventive services at http://www.hrsa.gov/womensguidelines/. If you do not have internet access, please call us at the telephone number on your ID card.

When there are material changes in the recommendations or guidelines that result in the cessation of providing Covered Health Care Services for preventive care services, at any time other than renewal, we will provide sixty days advance notice to you.

29. 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 Medically Necessary minimum specifications for your needs. If you purchase a prosthetic device that exceeds these Medically Necessary minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the Medically Necessary 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. Prosthetic devices are those devices that are listed as covered services in the Medicare fee schedule for durable medical equipment, prosthetics, orthotics and supplies, but only to the extent consistent with this section.

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

30. 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, Congenital Anomaly, or which are determined to be Medically Necessary. The primary result of the procedure is not a changed or improved physical appearance.

Benefits are provided when Medically Necessary for cosmetic or reconstructive surgery in the following situations:

- When necessary to correct a functional disorder; or
- When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. Cosmetic or reconstructive surgery must take place within 18 months or as Medically Necessary after the injury, surgery, scar, or defect first happened. Preauthorization is required for all cosmetic and reconstructive surgeries.
- We will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.

Benefits include maxillofacial prosthetic services necessary to restore head and facial structures that cannot be replaced by living tissue and are defective because of disease, trauma or birth and developmental deformities when performed for any of the following purposes:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures to improve on the normal range of conditions.

Maxillofacial prosthetic services also include fluoride gel carrier, but is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed to be insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier.

Benefits include dental and orthodontic services for the treatment of craniofacial anomalies if the services are Medically Necessary to restore function. For the purposes of this Benefit, "craniofacial anomaly" means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Also included are dental or orthodontic services for developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

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.

31. Rehabilitation Services - Outpatient Therapy

Short-term Outpatient rehabilitation services limited to:

- Physical therapy.

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

Benefits may include additional rehabilitation services for the Medically Necessary treatment of severe neurologic conditions, not to exceed 60 visits per year, when criteria are met. (Examples of neurologic conditions include stroke, spinal cord injury, and head injury, for which rehabilitation services would be appropriate for children). Visit limits do not apply if the rehabilitation services are for the primary treatment of a behavioral health diagnosis, and the medical necessity and clinical appropriateness of the service will be used as the basis for authorizing coverage.

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

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

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

Benefits are not available for maintenance/preventive treatment.

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

32. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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.

34. Spinal Manipulative Treatment Services

Short term Outpatient Spinal Manipulative Treatment Services provided by a licensed Doctor of Chiropractic (D.C.).

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

- You are not progressing in goal directed Spinal Manipulative Treatment Services,
- Spinal Manipulative Treatment Services goals have previously been met.

Benefits under this section are not available for maintenance/preventive Spinal Manipulative Treatment Services.

35. 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 vasectomy and certain scopic procedures. Examples of surgical scopic procedures are:

- 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*.)

36. Therapeutic Treatments - Outpatient

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

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

37. Transplantation Services

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

Examples of transplants for which Benefits are available include:

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

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

- Identification.

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

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

38. 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*.

39. 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.

Additional Benefits Required By Oregon Law

40. Autism Spectrum Disorder - Medical Services

Medical services, including physical, occupational, and speech therapy, for Covered Persons who have been diagnosed with Autism Spectrum Disorder when such services are Medically Necessary as determined by your Physician and are not otherwise excluded under *Section 2: Exclusions and Limitations*.

41. Cochlear Implants

Cochlear implants (including bilateral cochlear implants if medically appropriate for the treatment of hearing loss) and Covered Health Care Services required for implantation when provided by a Physician. Benefits include coverage of programming and reprogramming, Benefits also include repair and replacement parts for cochlear implants when not covered by a warranty and are necessary for the device to be functional.

42. Hearing Assistive Technology Systems and Bone Conduction Sound Processors

Benefits are available for hearing assistive technology systems for a Covered Person who is younger than 19 years of age, if necessary, for appropriate amplification of the hearing loss. For the purpose of this Benefit "hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Benefits are also available for bone conduction sound processors, if necessary, for appropriate amplification of hearing loss.

Please contact us at the telephone number shown on your ID card for specific coverage requirements.

43. Hearing Loss Diagnostic and Treatment Services

Benefits are available for necessary diagnostic and treatment services at least twice per year for Covered Persons who are younger than four years of age and at least once per year for Covered Persons who are four years of age or older, including:

- Hearing tests appropriate for a Covered Persons age or developmental need;
- Hearing aid checks; and
- Aided testing.

Please contact us at the telephone number shown on your ID card for specific coverage requirements.

44. Oregon Universal Newborn Nurse Home Visiting Program

Coverage will be provided on behalf of a newborn child, up to the age of six months, who is enrolled under the plan and who resides in an area of state that is served by a universal newborn nurse home visiting program approved by the *Oregon Health Authority (OHA)*.

Covered Health Care Services include:

- An evidence-based assessment of the physical, social and emotional factors affecting the family;
- Covered Health Care Services are offered to all families with newborns residing in the community where the program operates;
- At least one visit during a newborn's first three months of life with the opportunity for the family to choose up to three additional visits;
- A follow-up visit no later than three months after the last visit; and
- Information and referrals to address each family's identified needs.

45. Telemedical Services

Benefits are provided for applicable Covered Health Care Services delivered through "Telemedical" services to the same extent as other Covered Health Care Services. Benefits are also provided for Remote Physiologic Monitoring.

"Telemedicine" means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care. For purposes of telemedical benefit, an "originating site": includes, but is not limited to a Hospital; Rural health clinic; Federally qualified health center; Physician's office; Community behavioral health center; Skilled nursing facility; Renal dialysis center; or a site where public health care services are provided; where the patient resides or the physical location of the patient.

For the purpose of this benefit "Health service" means physical, oral and behavioral health treatment or service provided by a health professional.

For telemedical health care services coverage is available when communication is provided between providers or between one or more providers and one or more patients, family members, caregivers or guardians. Benefits include coverage of a health service that is provided using synchronous and asynchronous two-way interactive video conferencing if:

- The plan provides coverage of health care service when provided in person by a health professional;
- The health care service is Medically Necessary;
- The health service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

- The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.

Permissible telemedicine applications and technologies include:

- Landlines, wireless communications, the Internet and telephone networks; and
- Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.

During a state of emergency, a health benefit plan or dental-only plan shall provide coverage of a telemedicine service delivered to an Enrollee residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

"Health professional" means a person licensed, certified or registered in Oregon to provide health care services or supplies. For telemedical health care services provided in connection with the treatment of diabetes, "telemedical" coverage is available when communication is provided between providers or between one or more providers and one or more patients, family members, caregivers or guardians, using landlines, wireless communications, the Internet and telephone networks and synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.

On-Demand National Providers

Telemedicine Services may be available from On-Demand National Providers. These On-Demand National Providers are able to provide telemedicine services received outside of a medical facility (for example, from home or from work) for the diagnosis and treatment of less serious medical conditions. Covered Health Care Services, including urgent on-demand care can also be provided from providers who are not On-Demand National Providers. Communication of medical information is provided in real-time between the patient and the distant Physician or health specialist. You can find an On-Demand National Provider by contacting us at www.myuhc.com or the telephone number on you ID card.

For the purpose of this Benefit, "less serious medical conditions" may include conditions such as a cough, cold, fever, pink eye, rash and other minor conditions.

Benefits through On-Demand National Providers are available for urgent on-demand care delivered through live audio with video conferencing technology for treatment of acute but non-emergency medical needs.

46. Tobacco Use Cessation

Coverage is provided for Covered Persons fifteen years old or older for tobacco use cessation programs including both educational and medical treatments to help a person overcome nicotine addiction. Qualifying programs must be recommended by a Physician who follows the *United States Public Health Service* guidelines.

47. Voluntary Sterilization Procedures for Men and Termination of Pregnancy

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

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. The exclusions in this section may apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits unless for an Emergency Medical Condition or if Medically Necessary for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Behavioral Health Care and Substance-Related and Addictive Disorders

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

1. Services performed in connection with conditions not classified 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. Educational services that are focused primarily on building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Covered Health Care Services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified health care professional and are provided by a provider acting within the scope of his or her license.
3. Tuition for 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.*
4. Transitional Living services.
5. Non-Medical 24-Hour Withdrawal Management.
6. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria*, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

C. Dental

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

   This exclusion does not apply to accident-related dental services for which Benefits are covered in the same manner as all other Emergency Health Care Services and are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

   This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

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

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

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

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

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

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are covered in the same manner as all other Emergency Health Care

Services and are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

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

   This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

4. Dental braces (orthodontics). This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental or orthodontic services for the treatment of craniofacial anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

D. Devices, Appliances and Prosthetics

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

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

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

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

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

5. Oral appliances for snoring.

6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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

8. Powered and non-powered exoskeleton devices except as covered in *Section 1: Covered Health Care Services* under *Durable Medical Equipment (DME), Orthotics and Supplies*.

E. Drugs

1. Prescription drug products for Outpatient use that are filled by a prescription order or refill, except for orally administered anti-cancer medication used to kill or slow the growth of cancerous cells.

For additional Benefit coverage details including orally administered anti-cancer medication, please refer to the *Outpatient Prescription Drug Rider*.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration. This does not apply to Benefits provided under the *Outpatient Prescription Drug Rider*. Please see the *Outpatient Prescription Drug Rider* for details on those Benefits.

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

4. Over-the-counter drugs and treatments. This does not apply to Benefits provided under the *Outpatient Prescription Drug Rider*. Please see the *Outpatient Prescription Drug Rider* for details on those Benefits.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

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

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product with an approved biosimilar 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 referenced product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

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

F. Experimental or Investigational or Unproven Services

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

This exclusion does not apply to prescription drugs which have not yet been approved by the *Food and Drug Administration* 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 publications that the *Health Resources Commission* determines to be equivalent to:
  - *The American Hospital Formulary Service Drug Information.*
  - *Drug Facts and Comparisons (Lippincott-Raven Publishers).*
  - *The United States Pharmacopoeia Dispensing Information, Volume 1*.
  - Other publications that have been identified by the *United States Secretary of Health and Human Services* as authoritative.
- In the majority of relevant peer reviewed medical literature.
- By the *United States Secretary of Health and Human Services*.

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

G. Foot Care

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

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports, except as required under DME.

H. Medical Supplies and Equipment

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

   This exclusion does not apply to:

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

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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, except that Benefits include education by a certified diabetic educator as described under *Diabetes Services* in *Section 1: Covered Health Care Services*. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral health related nutritional education services that are provided as part of the treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

J. Personal Care, Comfort or Convenience

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

- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- 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 definitions in *Section 9: Defined Terms.* Drugs, devices and procedures related to Cosmetic Surgery or Cosmetic Services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Covered Person's dissatisfaction with his or her appearance. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which

Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of veins.
- Hair removal or replacement by any means.

  This exclusion does not apply to Covered Health Care Services described in *Gender Dysphoria* under *Section 1: Covered Health Care Services*.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure, except if Medically Necessary to correct damages or leaks following an Injury or illness. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, except as covered in *Section 1: Covered Health Care Services* under *Preventive Care Services*.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services 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.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke. This exclusion does not apply to cognitive therapy for the treatment of Autism Spectrum Disorder for which Benefits are provided as described under *Autism Spectrum Disorder Services - Behavioral, Autism Spectrum Disorder Services - Medical* and *Habilitative Services* in *Section 1: Covered Health Care Services*.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Services for the evaluation and treatment of TMJ, whether the services are considered to be medical or dental in nature.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.

12. Surgical and non-surgical treatment of obesity, except those services on the "A" & "B" list of preventive services as recommended by the *United States Preventive Services Task Force (USPSTF)* for obesity screening and counseling for children and adults.

13. Breast reduction surgery. This exclusion does not apply to Benefits described under *Gender Dysphoria* in *Section 1: Covered Health Care Services* or to coverage 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.

16. Cellular and Gene Therapy services not received from a Designated Provider.

M. Providers

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

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

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

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

   This exclusion does not apply to mammography or Emergency Medical Conditions or urgently needed services.

N. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

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

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

- Screenings and/or diagnostic testing.
- Delivery and post-natal care.

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

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

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*
5. The reversal of voluntary sterilization.
6. Elective fertility preservation.
7. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

O. Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

P. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

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 as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

R. Types of Care

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

S. Vision and Hearing

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

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

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

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Behavioral Health Condition, 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 other than those requiring coverage for payment of screening and treatment programs for driving under the influence or the diagnostic assessment for purposes of a diversion program under ORS 813.200 et seq. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received after the date your coverage under the Policy ends except for Covered Persons who are hospitalized on the date of termination and coverage is immediately replaced by a group health insurance policy issued by another insurer. Such coverage ceases once the Covered Person is discharged from the Hospital. This exclusion applies to health care services (other than hospitalization); even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
4. 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.
5. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
6. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
7. Autopsy.
8. 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.
9. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient or Outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where

they attend school during the school year. This exclusion does not apply in the case of an Emergency Medical Condition or if authorization has been obtained in advance.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

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

Eligible Employee

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

Eligible Employees must live within the United States.

If both spouses are Eligible Employees 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 or same sex Domestic Partner 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 Employee may not enroll unless the Eligible Employee 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 Employees 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 Employees 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 Employee becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Employees 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 Employee becomes eligible.

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year, the Group will provide a 30-day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Employees

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

Adding New Dependents

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

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

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

For a Dependent child by reason of birth, adoption or placement for adoption, coverage takes effect on the date of birth, adoption or placement for adoption and continues for 31 days even if the Subscriber fails to notify us. In order to continue coverage beyond the initial 31 days, we must receive the completed enrollment form along with payment for the entire period following the birth, adoption or placement for adoption.

Special Enrollment Period

A "Late Enrollee" is an Eligible Employee and/or Dependent who may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Employee 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 Employee and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Employee and/or Dependent even if COBRA is not elected.

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a same sex Domestic Partnership.

A special enrollment period also applies for an Eligible Employee 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 Employee previously declined coverage under the Policy, but the Eligible Employee 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 Employee 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 Employee 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 Employee 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 Employee and/or Dependent.
    - The Eligible Employee and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

For a Dependent child by reason of birth, adoption or placement for adoption, coverage takes effect on the date of birth, adoption or placement for adoption and continues for 31 days even if the Subscriber fails to notify us. In order to continue coverage beyond the initial 31 days, we must receive the completed enrollment form along with payment for the entire period following the birth, adoption or placement for adoption.

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

Renewal and Reinstatement (Renewal Provisions)

Your Policy with us renews automatically, on a yearly basis, subject to all terms of the Policy. We may not renew the Policy in the event of nonpayment of Premiums, fraud, violation of participation or contribution rates, market exit, or movement outside the service area. We or your Employer Group may change your Policy Benefits and Premium at renewal. If the Policy is terminated by us, reinstatement is subject to all terms and conditions of the Policy. In accordance with our Policy, the Employer Group is required to notify employees who are our Covered Persons of any such amendment or modification.

Form of Notice to Group

The notice to the Group, containing information that applies to the Group and Subscriber, will be printed in 12-point type, one point leaded, and will provide at least the following:

- The date of the notice;
- A statement to the effect that the group coverage provided through the Group by the us has terminated or will terminate, and the effective date of termination. If termination will occur because of nonpayment of Premium, the statement will also provide that the Premium was not received, that the Policy will be terminated as of the Premium due date if the Premium is not received by the end of the grace period applicable to the Policy and that the insurer will furnish no further notice as to termination, and must include the date of termination. The effective date of a termination for a reason other than nonpayment of Premium shall be the date preceding the first day that a group policy is effectively without coverage under the group health insurance policy;
- The number of the group health insurance policy;
- The name of the Employer;
- An explanation of the rights of the certificate holders under federal law and state law regarding the continuation of coverage.

The notice will be mailed by first class mail to the last known address of the Group at least 10 working days prior to the end of the grace period under the Policy. Alternatively, the notice may be given to the Group electronically if, at the time of application or renewal, the insurer allows an applicant or Enrollee the opportunity to receive such notices by regular mail, and the Enrollee fails to exercise that opportunity.

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.

  When the Policy ends and is not replaced, we will send written notice to the Group of the termination, not less than 10 working days after the date the Policy ends, explaining the rights to continuation coverage under federal and state law. The Group is responsible for giving you that information.

- **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 Employee," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

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

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

We will provide at least 30 days advanced written notice to each participant who would be affected prior to the termination.

Under no circumstances will a Covered Person be terminated due to health status or the need for health care services. If a Covered Person is Totally Disabled when the Group's coverage ends, coverage for the Totally Disabling condition may be extended. Any Covered Person who believes his or her enrollment has been terminated due to the Covered Person's health status or requirements for health care services may request a review of the termination by the *Division of Financial Regulation*. For more information call us at the number on the back of your ID card.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a 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 behavioral, 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. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

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

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

Extended Coverage for an Inpatient Stay

If you are an inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility at the time the Policy is terminated and immediately replaced by coverage under a Policy issued by another carrier, your Benefits will be temporarily extended. Benefits will be extended only for the treatment of the condition that has caused the Inpatient Stay.

Benefits will be extended until the date you are discharged from the Inpatient Stay.

These extended Benefits are subject to all terms, conditions, limitations and exclusions of the Policy that is in effect on the day immediately prior to the date coverage would otherwise end.

Continuation of Coverage

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

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 of Benefits After Termination of Group Health Insurance Policy

As described in *Extended Coverage for an Inpatient Stay* above, we will fulfill our obligation to provide coverage for Benefits under the Policy for any person insured under the Policy, who is hospitalized on the date of termination, regardless of whether the Policy is ended and immediately replaced by a group health insurance policy issued by another insurer. Coverage will remain uninterrupted when the existing Policy is replaced. Any payment required under this section is subject to all terms, limitations and conditions of the Policy, except those relating to the termination of Benefits. Our obligation under this section continues until the Hospital confinement ends or Hospital Benefits under the Policy are exhausted, whichever is earlier.

Continuation Coverage under State Law for Surviving, Divorced, or Separated Spouses or Same Sex Domestic Partner Age 55 and Older

The Subscriber's surviving, divorced, or legally separated spouse or same sex Domestic Partner may continue coverage under the Policy for themselves and any Enrolled Dependents if either of the following apply:

- The spouse or same sex Domestic Partner and the Dependent children were covered under the Policy and lost coverage because of the death of the Subscriber, and the spouse or same sex Domestic Partner was 55 years of age or older at the time of the death of the Subscriber.
- The spouse or same sex Domestic Partner and Dependent children were covered under the Policy and lost coverage because of the divorce or legal separation of the spouse or same sex Domestic Partner and the Subscriber, and the spouse or same sex Domestic Partner was 55 years of age or older at the time of the divorce or legal separation.

In order to obtain continuation coverage under this provision, the legally separated or divorced spouse or same sex Domestic Partner must notify the Group of the legal separation or divorce within 60 days of the separation or the entry of a decree of dissolution of marriage. The Group's plan administrator must notify the spouse or same sex Domestic Partner of the right to continuation under this provision within 14 days of the date the plan administrator receives notice of the separation or divorce. The plan administrator will provide the spouse or same sex Domestic Partner with an election form for continuation coverage and a statement of the periodic Premiums to be charged for the continuation coverage. The spouse or same sex Domestic Partner must return the continuation coverage election form with any applicable Premiums to the Group's plan administrator within 60 days of the date the administrator mailed the notice. If the spouse or same sex Domestic Partner fails to comply with the procedures provided in this provision, the spouse or same sex Domestic Partner will lose all rights to continuation of Benefits under this provision.

In the event of death of the Subscriber, the Group shall provide the plan administrator written notice of the death and the mailing address of the surviving spouse or same sex Domestic Partner.

The spouse or same sex Domestic Partner must submit the election form for continuation coverage to the plan administrator within 30 days of the date the notice of election form was first mailed to the spouse or same sex Domestic Partner.

A spouse or same sex Domestic Partner who requests continuation coverage under this subsection must pay the required Premium for the spouse or same sex Domestic Partner and for any Dependent children, on a monthly basis on the same date required of the Group. The surviving divorced or separated spouse or same sex Domestic Partner of a Subscriber is not entitled to continuation coverage, or else continuation coverage will end if any of the following apply:

- The failure to pay Premium when due, including any grace period allowed under the Policy.
- The date that the Policy is ended as to all Subscribers under the group except that a different group policy is made available to all Subscribers of the group, the legally separated, divorced or surviving

spouse or same sex Domestic Partner shall be eligible for continuation coverage as if the original Policy had ended.

- The date in which the legally separated, divorced or surviving spouse or same sex Domestic Partner becomes insured under any other group health plan.
- The date on which the legally separated, divorced or surviving spouse or same sex Domestic Partner remarries and becomes covered under another group health plan.
- The date in which the legally separated, divorced or surviving spouse or same sex Domestic Partner becomes eligible for federal Medicare coverage.

Same-sex married couples validly married in other states now qualify as spouses under state continuation.

Continuation Coverage under State Law upon Termination of Employment Due to a Work-Related Injury or Sickness

A Subscriber who incurs an injury or illness, for which a workers' compensation claim is filed, may continue coverage under the Policy. For continuation to happen, the Subscriber must pay the entire Premium for him or herself and for all Enrolled Dependents on a timely basis. The Subscriber may maintain coverage until whichever of the following events first happens:

- The Subscriber takes full-time employment with another employer.
- Six months from the date that the Subscriber first makes payment under this section.
- Failure to pay Premium when due, including any grace period allowed under the Policy.
- The date that the Policy is ended as to all Subscribers under the group except that if a different group policy is made available to all Subscribers of the group, the Subscriber shall be eligible for continuation coverage as if the original Policy has ended.
- The date in which the subscriber becomes insured under any other group health plan.
- The date in which the Subscriber becomes eligible for federal Medicare coverage.

A Subscriber must request continuation coverage in writing within 10 days after the later of the date on which employment is terminated, or the date on which the Group gives the Subscriber notice of the right to continue coverage under this provision. The Subscriber may not make a request for continuation more than 31 days after the date coverage ended.

Continuation Coverage under State Law for Strikes or Lockouts

Should the Premiums be paid by the Group under the terms of a collective bargaining agreement and there is cessation of work by the Subscriber due to a strike or lockout, then the Benefits offered under the Policy shall continue in effect provided that the Subscriber continues to pay the amount due form the Group in accordance with the terms of the Policy. The union that represents the Subscriber will be responsible for collecting the Premiums and paying them to us on or before the date the Premiums are due. The amount of the Premium to be paid by such Subscriber and his or her Enrolled Dependents belong, subject to a maximum increase of 20% to pay for our increased administrative costs. Nothing in this section shall be deemed to limit any right we may have in accordance with the terms of the Policy to increase or decrease the Premiums. Coverage under the section shall continue only until any one of the following happens:

- The date less than 75% of the Subscribers continue coverage.
- Six months after cessation of work by the Subscriber.
- The date the Subscriber takes full-time employment with another employer.

- The date the strike or lockout ends, and the Policy returns to regular coverage.
- The date Premiums are not received in a timely fashion.

If the Premiums due under the Policy are unpaid at the date of cessation of work, and had become due prior to such cessation of work, continuation coverage described under this Section is contingent upon payment of applicable Premiums prior to the next Premium Due under this Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. We will provide a claim form to you within 15 days after we receive notice of any claim under this Policy. If we do not provide a claim form to you within this timeframe, you will have been deemed to have complied with the requirements of this Policy as to proof of loss upon submitting written proof covering the occurrence, character and the extent of the loss for which the claim is made within the proof of loss time frame described below. You must file the claim in a format that contains all of the information we require, as described below.

You must submit a request for payment of Benefits within 20 days after the date of service or as soon as is reasonably possible. 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, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. Notice given by you or on your behalf to us at the address on your ID card, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

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

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

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

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.
- The Benefit is for ambulance transportation, in which case Benefits will be paid directly to the ambulance service provider.

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.

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. You have the right to request a confidential communication request which means a request from you to us that communications are sent directly to you and that we refrain from sending communications concerning you to the Group or Subscriber. Call us at the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday for you to make this request to be sent the confidential communication request form.

What if You Have a Complaint?

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

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

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written Complaint. We will notify you of our decision regarding your Complaint within 30 days of receiving it.

You have the right to file a Complaint or seek assistance from the *Division of Financial Regulation* who can be reached:

- By calling (503) 947-7984 or the toll free message line at (888) 877-4894.
- By electronic mail at: DFR.InsuranceHelp@oregon.gov
- By writing to the:

  Division of Financial Regulation

  Consumer Advocacy Unit

  P.O. Box 14480

  Salem, OR 97301-0405; or

  Website: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request a Grievance/Appeal

It is your right to file a grievance/appeal. If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request a grievance/appeal.

A "Grievance" is a request submitted by you or your Authorized Representative, that is:

- In writing, for an internal appeal or an external review; or
- In writing or orally, for an expedited review or an expedited external review; or
- A written Complaint submitted by you or your Authorized Representative regarding the:
  - Availability, delivery or quality of a heath care service;
  - Claims payment, handling or reimbursement for health care services and, unless the Covered Person has not submitted a request for an internal appeal, the Complaint is not disputing an Adverse Benefit Determination; or
  - Matters pertaining to the contractual relationship between a Covered Person and us.

"Internal appeal" means a review by an insurer of an Adverse Benefit Determination made by the insurer.

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

Grievance/Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the grievance/appeal. If your grievance/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 grievance/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 grievance/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.

Grievance/Appeals Determinations

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

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

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

- Within seven days of receipt of a grievance/appeal, we will send written acknowledgment of receipt to you or your Authorized Representative.

- For grievance/appeals of pre-service requests for Benefits as defined above, the grievance/appeal will take place and you will be notified of the decision within 30 days from receipt of a request for a grievance/appeal of a denied request for Benefits.
- For grievance/appeals of post-service claims as defined above, the grievance/appeal will take place and you or your Authorized Representative will be notified of the decision within 30 days from receipt of a request for grievance/appeal of a denied claim.

You are entitled to receive continued coverage of the disputed health care service or item pending the conclusion of the grievance/appeal process. However, you will be financially responsible to pay for the disputed health care service or item if our denial is not reversed.

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

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

Urgent Grievance/Appeals that Require Immediate Action

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

Appealing a Health Care Decision or Requesting a Quality Review

Submitting a Grievance

Our grievance system provides you with a method for addressing your dissatisfaction regarding coverage decisions, care or services.

Our appeals and quality review procedures are designed to resolve your grievance. This is done through a process that includes an appropriate investigation, as well as an evaluation of the Grievance. To begin an appeal or request quality review, call us at the telephone number on your ID card or write the Appeals department at:

UnitedHealthcare

Appeals and Grievance Department

PO Box 6107 Mailstop CA124-0160

Cypress, CA 90630-9972

Standard Fax: 1-866-704-3420

Expedited Fax: 1-800-346-0930

Expedited Appeals Telephone #: 1-888-277-4232

You may also file an appeal using the online grievance form at www.myuhc.com.

This written request will begin the following appeals or quality review process except in the case of "expedited reviews" as discussed below. You or your Authorized Representative may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. 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.

We will review your Complaint, and if it involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or used, the determination will be made by a medical reviewer health care professional 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 your appeal.

External Review Program

You have the right to apply for an external review by an Independent Review Organization within 180 days of receipt of our final Adverse Benefit Determination.

You may be entitled to request an external review of our determination after exhausting your internal grievance/appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

You are eligible to request an external review by an *Independent Review Organization (IRO)* upon receiving your final Adverse Benefit Determination.

You or your Authorized Representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. When an internal appeal is upheld, you will be provided with the required Release of Information form with your Final Adverse benefit Determination Appeal Uphold letter. If you wish to proceed with the external review, this form must be completed, signed and returned to us with your request for external review. A request must be made within 180 days after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your Authorized Representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal grievance/appeal.
- A current signed Release of Information granting the *IRO* access to your medical records for the external review's services identified in the determination letter.

We will notify the Director of the *Department of Consumer and Business Services (DCBS)* no later than two business days after receipt of the external review request.

The Director of the *Department of Consumer and Business Services* will contract with and appoint the *IRO*. We will supply the signed release granting the *IRO* access to your medical records within five business days following the notice the *IRO* is assigned by the Director. Once the Director refers a dispute, the *IRO* must proceed to a final decision in accordance with the procedural requirements by Oregon

administrative rules, unless requested otherwise by both the insurer and the Enrollee. An *IRO* must decide whether or not the dispute pertains to an Adverse Benefit Determination. If the dispute is covered, it is eligible for external review. An *IRO* must also decide whether the dispute concerns a covered benefit in the Health Benefit Plan. If the dispute concerns a non-covered benefit, the dispute does not qualify for external review.

You may submit additional information to the *IRO* no later than five business days after you receive notification of the appointment of an *IRO*, or within 24 hours in the case of an expedited external review.

The *IRO* will make a decision not later than the 30th day after you applied for external review. Written notification of the decision will be issued by the *IRO* within five days of the decision date.

If The IRO Failed To Comply With Procedural Requirements

An *IRO's* decision shall be final unless, within seven business days of an Enrollee's receipt of the written report of the *IRO's* decision, the Enrollee submits information to the director that the *IRO* failed to materially comply with the procedural requirements. (Note: "procedural requirements" does not include requirements related to the exercising of medical judgment or decision making by the *IRO*.) If the Enrollee is satisfied with the independent review organization's decision, the Enrollee may notify *IRO* and insurer by electronic mail, fax or telephone, followed by a written notice, stating that the Enrollee waives the seven business days before the *IRO's* decision is final.

The director shall review the information submitted by the Enrollee and, within seven business days, make a written determination whether:

- The director is reasonably satisfied that the *IRO* failed to materially comply with the procedural requirements; and
- The *IRO's* failure to materially comply with the procedural requirements materially affected *IRO's* decision.

The director shall send a written notification of the determination to the Enrollee and the *IRO*. The *IRO's* decision will be final if the director is reasonably satisfied that the *IRO* complied with the procedural requirements. If an *IRO* failed to materially comply with the procedural requirements, the *IRO* shall correct the failure to materially comply by conducting a new external review, at the *IRO's* cost, and issue a new decision within ten business days.

Within 24 hours of receipt of the written notification from the director, the *IRO* shall:

- Notify the Enrollee and the insurer via electronic mail, fax or telephone that the *IRO* will be conducting a new external review, and
- Request form the Enrollee or the insurer via electronic mail or fax any information not already provided to the *IRO* that is necessary to correct the material failure to comply with the procedural requirements.

The Enrollee or insurer must provide to the *IRO* any requested information within 48 hours after receipt of the request.

Notification of the *IRO's* new decision shall be provided to the Enrollee and insurer initially via electronic mail, fax or telephone, followed by a written report by mail.

The *IRO's* decision based on the new external review shall be final as of the date of the decision.

We will incur all costs of the external review program.

Expedited External Review

An external review will be expedited when:

- The Adverse Benefit Determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which you received Emergency Health Care Services and have not been discharged from a health care facility; or
- A provider with an established clinical relationship with you certifies in writing and provides supporting documentation that the ordinary timeframe for a standard external review would seriously jeopardize your life or health or your ability to retain maximum function.

When the review is expedited, the *IRO* will issue a decision no later than the third day after the date you applied for external review.

Expedited Review Appeals Process

Appeals involving a clinical urgency - an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function - will be immediately referred to our clinical review personnel. In such clinical urgencies, we will explain the circumstances in which external review can be expedited. We and the *DCBS* director shall expedite the external review. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, we will immediately inform you of your review status and your right to notify the *Division of Financial Regulation* of the grievance. You and the *Division of Financial Regulation* will be provided with a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the grievance.

Waiving the Grievance/Appeal Process and Proceeding Directly to External Review

For Adverse Benefit Determinations eligible for expedited external review, you are not required to complete our internal grievance/appeal process, including our expedited internal grievance/appeal process, before requesting an expedited external review. You may request an expedited external review before exhausting our grievance/appeal process and may proceed directly to external review by an *IRO*.

We may choose to waive the grievance/appeal process at any time for Adverse Benefit Determinations eligible for external review. If we waive the grievance/appeal process, the grievance/appeal process is deemed to have been exhausted for purposes of qualifying for external review.

You are deemed to have exhausted the internal grievance/appeal process if we do not comply with applicable regulations regarding timing of the response to an internal grievance/appeal.

Binding Nature of the External Review Decision

We agree to be bound by a decision of an IRO and may be penalized by the Department of Consumer and Business Services if it fails to follow the decision of an IRO. You have the right to sue us if the IRO's decision is not implemented by us.

We must comply in a timely manner with a decision by an *IRO* that reverses, in whole or in part, an Adverse Benefit Determination.

The Covered Person who is the subject of a decision by an *IRO* has a private right of action against us for damages arising from an Adverse Benefit Determination if we fail to comply with the *IRO's* decision.

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

1. A "Plan" includes: group and individual insurance contracts and subscriber contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); group-type contracts; 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, and/or group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

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; 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.

"Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if: (a) the plan has no order of benefit determination rules or its rules differ from those permitted by state rule; or (b) all plans that cover the person use the order of benefit determination rules required state rule, and under those rules the plan determines its benefits first.

"Secondary plan" means a plan that is not a primary plan.

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

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

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

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

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

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

5. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

6. When a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid.

7. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these

types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Birthday.** "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

F. **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.

G. **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.

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

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

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

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

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

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

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

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

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

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

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

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse or same sex Domestic Partner does, that parent's spouse's or same sex Domestic Partner's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse or same sex Domestic Partner.

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

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

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) For a dependent child who has coverage under either or both parents' plans and who also has coverage as a dependent under a spouse or same sex Domestic Partner's plan.

(i) The plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the Covered Person was eligible under the second plan within 24 hours after coverage under the first plan ended.

(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 during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

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

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

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

Special Note Regarding Medicare When Primary

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 this section. You are not required to obtain authorization before receiving Covered Health Care Services.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, 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 and Written Information to Group

When we provide written notice regarding administration of the Policy, including but not limited to information relating to the Enrollee's rights and responsibilities, the right to appeal Adverse Benefit Determinations, services, access and related charges and access to external review, 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 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, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

We will do all of the following:

- Pay Benefits according to the Policy.
- Pay Benefits according to this 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.

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

We may change, modify, withdraw, or add Benefits, or end the Policy, as permitted by law. We will provide you with advance notices, when required, when we change, modify, withdraw or add Benefits or when we 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.

Modification of a Health Benefit Plan Subject to Levels of Coverage Requirements.

One or more decreases or increases in the services or Benefits covered in a Health Benefit Plan are a modification and not a discontinuance when the decrease or decreases or the increase or increases, or any combination thereof, happen at the time of renewal and the change or changes together do not alter the level of coverage. One or more decreases or increases in the services or Benefits covered in a Health Benefit Plan are a discontinuance when the decrease or decreases, or the increase or increases, or any combination thereof, alter the level of coverage.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We may 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 may release records concerning health care services when any of the following apply:

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

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

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

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

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

The following additional information regarding UnitedHealthcare is available upon request:

- Grievance and Appeals, Annual Summary.
- Utilization Review Policies, Annual Summary.
- Quality Improvement Activities, Annual Summary.
- Results of all publicly available accreditation surveys.
- Health promotion and Disease Prevention Activities, Annual Summary.
- Provider Network and Accessibility Services, Annual Summary.

You can request the above information from the *Oregon Division of Financial Regulation* who can be reached:

- By writing to the:

  Oregon Division of Financial Regulation

  P.O. Box 14480

  Salem, Oregon 97309-0405
- By Calling: Phone 503-947-7984, Fax: 503-378-4351 or the toll free message line at 888-877-4894
- By electronic mail (Email) at DFR.InsuranceHelp@oregon.gov
- Website: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

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. We may not exclude, and shall expedite preauthorization required for work-related injuries or occupational diseases if:

- The injured worker is covered by workers' compensation insurance and the Health Benefit Plan; and
- The injured worker has submitted a workers' compensation claim for the work-related injury or occupational disease that has not been accepted or denied by the workers' compensation carrier.

We will provide an expedited pre-authorization no later than the third day after the date on which the request for expedited pre-authorization is submitted. We are bound by Oregon law to guarantee payment for preauthorized medical services to the provider of those medical services according to the terms, conditions, and Benefits of the plan if the claim is found not to be a compensable workers' compensation claim.

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.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, 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. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine", claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- We will not reduce our reimbursement or subrogation due to your not being made whole unless such a reduction is required by applicable law. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- 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, and failure to hold funds may instigate legal actions against you.
- 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.
- We have the authority to resolve all 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 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 another person or organization, you agree to help us get the refund when requested.

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

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

Is There a Limitation of Action?

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.

Non-discrimination Notice

We do not exclude, deny Covered Benefits to, or otherwise discriminate against any Covered Person on the grounds of race, color, sex, religion, sexual orientation, Gender Dysphoria, genetic tests and information, marital status, or national origin, or on the basis of disability or age, participation in or receipt of the Covered Services under, any of its Health Plans whether carried out by us directly or through a Participating/Contracting Medical Group or any other entity with which we arrange to carry out Covered Services under any of its Health Plans. Genetic information of you or a family member will not be used to affect your rights to coverage under this Policy or your eligibility for coverage.

We do not deny insurance or cancel a health insurance policy because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth, or discriminate against providers acting within the scope of their licensure or certification.

This statement is in accordance with the provisions of *Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services (DHHS)* issued pursuant to these statutes at Title 45 Code of Federal Regulations

- Part 80 - Nondiscrimination under programs receiving federal assistance through the *DHHS*
- Part 84 - Nondiscrimination handicap in programs or activities receiving federal financial assistance
- Part 91 - Nondiscrimination age in programs or activities receiving federal financial assistance from *DHHS*.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats.
- 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 the toll-free phone number listed on your ID card, TTY 711.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability, or sex, you can file a grievance with:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

You can file a grievance by mail or email. If you need help filing a grievance, your Civil Rights Coordinator is available to help you. You can also file a civil rights Complaint with the *U.S. Department of Health and Human Services*, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/oocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW., Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 8000-537-7697 (TDD)

1	Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
2	Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
3	Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
4	Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
5	Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
6	Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
7	Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランの ID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
8	Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
9	Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
10	Mon-Khmer, Cambodian	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
11	Cushite	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711

12	German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
13	Persian	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
14	French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
15	Thai	คุณมีสิทธิที่จะ ได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711

Coverage While Under the Custody of a Local Supervisory Authority

We may not deny reimbursement for any service or supply covered by the plan or cancel the coverage of an insured under the plan on the basis that:

- The insured is a detainee;
- The insured receives publicly funded medical care while in the custody of a local supervisory authority or in a detention facility, or;
- The care was provided by an employee/provider of a county or local supervisory authority or a detention facility, if the employee or contractor of a county or a local supervisory authority meets the credentialing criteria of the Health Benefit Plan.

We are bound by Oregon law to reimburse a county for the costs of covered services or supplies provided to a detainee, in an amount that is no less than 115% of the Medicare rate for the service or supply.

We may, however, do the following:

- Deny coverage for the treatment of injuries resulting from a violation of law;
- Exclude from any requirements for reporting quality outcomes or performance, any covered services provided to a detainee;
- Impose utilization under the Health Benefit Plan that apply to services provided by in-network providers to insureds who are not in custody or in a detention facility, including a requirement for prior authorization;
- Impose the requirements for billing and medical coding for covered services provided to a detainee that we impose on other providers;
- Deny coverage of diagnostic tests or health evaluations required, as a matter of course, for all detainees;
- Limit coverage of Hospital and ambulatory surgical center services provided to a detainee to services provided by in-Network hospitals and ambulatory surgical centers; and

- Reimburse an out-of-Network renal dialysis facility at either the in-network or the out-of-network rate paid by the insurer for dialysis provided to a detainee.

We also may not refuse to credential a health care provider who is an employee or contractor of a county or local supervisory authority or a detention facility on the basis that an employee or a contractor provides the services in a facility operated by the local supervisory authority in a detention facility.

- If we refuse to credential a health care provider who is an employee or contractor of a county, or local supervisory authority or a detention facility, we must give written notice to the provider explaining the reasons for the refusal.

For purposes of this provision the following terms have the following meanings:

"Detainee" means an insured who is:

- In the custody of a local supervisory authority pending the disposition of charges; or
- In a detention facility pending final adjudication by a juvenile court.

"Detention facility" means a facility established for the shelter or detention of children, wards, youths or youth offenders confined pursuant to a judicial commitment or order pending final adjudication of the case by the juvenile court.

Section 9: Defined Terms

Adverse Benefit Determination - a denial, reduction or termination of a health care item or service, or our failure or refusal to provide or to make a payment in whole or in part for a health care item or service that is based on our:

- Denial of eligibility for or termination of enrollment in the Policy;
- Rescission or cancellation of this Policy;
- Imposition of a source-of-injury exclusion, network exclusion, annual Benefit limit or other limitation on otherwise Covered Health Care Services;
- Determination that a health care item or service is Experimental, Investigational or not Medically Necessary, effective or appropriate; or
- Determination that a course or plan of treatment that a Covered Person is undergoing is an active course of treatment for purposes of continuity of care.

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

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

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

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

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 Behavioral Health Care Services or Substance-Related and Addictive Disorders Services on an Outpatient or inpatient or residential 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.

Authorized Representative - an individual who by law or by the consent of a Covered Person may act on behalf of the Covered Person.

Autism Spectrum Disorder - **(formerly known as Pervasive Developmental Disorder)** - a condition marked by persistent impairment in a reciprocal social communication and social interaction manifested by restricted, repetitive patterns of behavior, interest or activities as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

Behavioral Health Assessment - an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

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

Behavioral Health Clinician - a licensed psychiatrist, psychologist, certified nurse practitioner with a specialty in psychiatric behavioral health, clinical social worker, professional counselor or licensed marriage and family therapist, certified clinical social work associate, an intern or resident who is working under a board-approved supervisory contract in a clinical behavioral health field, or any other clinician whose authorized scope of practice includes behavioral health diagnosis and treatment.

Behavioral Health Crisis - a disruption in an individual's behavioral or emotional stability or functioning resulting in an urgent need for immediate Outpatient treatment in an emergency department or admission to a hospital to prevent serious deterioration in the individual's behavioral or physical health.

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

Behavioral Health Condition - any mental or substance use disorder covered by diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Test Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10),* or the *International Classification of Diseases, 11th Revision (ICD-11)*. The fact that a condition is listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Test Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11)* does not mean that treatment for the condition is a Covered Health Care Service.

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

Calendar Year - January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

Cancellation - means termination of a policy at a date other than its Expiration Date.

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.

Complaint - means an expression of dissatisfaction directly to an insurer that is about a specific problem encountered by an Enrollee or about a decision by an insurer or by an insurance producer acting on behalf of the insurer and that includes a request for action to resolve the problem or change the decision. "Complaint" does not include an inquiry as that term is defined in this section.

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

Cognitive Rehabilitation (CR) - a multidisciplinary treatment program designed to improve cognitive function and retrain an individual's ability to think, use judgement and make decisions. The focus of these therapeutic activities is to improve deficits in memory, attention, perception, visual processing, language, reasoning, learning, planning, judgement, and problem-solving. CR comprises tasks to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems. The goal of CR is to maximize functional independence with minimal interference from cognitive limitations.

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.

Coverage - includes Medically Necessary Benefits, services, prescription drugs and medical devices. "Coverage" does not include Co-insurance, Co-payments, deductibles, or other cost sharing, provider networks, out-of-Network coverage, wigs or administrative functions related to the provision of coverage, such as eligibility and medical necessity determinations.

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, Behavioral Health Condition, 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 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 determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

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

The following conditions apply:

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

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

Status as a Dependent will not be affected by the parent's marital status at the time of the child's birth, support and maintenance requirements for tax purposes, or residence requirements.

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

Designated Provider - a 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.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership. Same sex Domestic Partner is to be included the same as a married spouse, and should have the same rights and requirements as married spouses.

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

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must have completed and filed a Declaration of Domestic Partnership with the county clerk.

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 Employee - an employee who is eligible for coverage under a group Health Benefit Plan. An Eligible Employee must live within the United States.

Emergency Health Care Services - with respect to an Emergency Medical Condition:

- An appropriate emergency medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)*, including a Behavioral Health Assessment, 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 Medical Condition, 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 Medical Condition, 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 the purpose of this Benefit, an "emergency medical screening exam" means the medical history, exam and ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Medical Condition - a medical condition:

- That manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.
- That is a behavioral health crisis.

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

Enrollee - an employee, dependent of the employee or an individual otherwise eligible for a group, or individual Health Benefit Plan who has enrolled for coverage under the terms of the plan.

Exclusion Period - the period during which specified treatments or services are excluded from coverage.

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or

- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

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

Expiration Date - means the date upon which coverage under a policy ends. For a policy written for a term longer than one year or with no fixed Expiration Date, "expiration date" means the annual anniversary date of the policy.

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

Gender Dysphoria - "Gender Dysphoria" is a serious medical and behavioral health condition characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Generally Accepted Standards of Care - means:

- Standards of care and clinical practice guidelines that:
  - Are generally recognized by health care providers practicing in relevant clinical specialties; and
  - Are based on valid, evidence-based sources; and
- Products and services that:
  - Address the specific needs of a patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;
  - Are clinically appropriate in terms of type, frequency, extent, site and duration; and
  - Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, treating physician or other health care provider.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

Health Benefit Plan - any hospital expense, medical expense or hospital or medical expense policy or certificate, health care services contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal E*mployee Retirement Income Security Act of 1974*, as amended.

Health Benefit Plan does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of *CHAMPUS* services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to *Section 125 of the Internal Revenue Code of 1986*, as amended, when the benefits are provided in addition to a group Health Benefit Plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed three months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, that describes insurance against risk of loss assumed under less than fully insured employee Health Benefit Plan, coverage issued as a supplement to a liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which Benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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.

This definition includes any Hospital owned or operated by the State of Oregon or any community behavioral health and developmental program operated by the State of Oregon.

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 Employees may enroll themselves and their Dependents under the Policy.

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

Inpatient - specifically related to Essential Health Benefits, Inpatient includes but is not limited to: Surgery, Intensive Care Unit, Neonatal Intensive Care Unit, Maternity and Skilled Nursing Facility services, and Behavioral Health Care Services and Substance-Related and Addictive Disorders Services.

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.

Inquiry - means a written request for information or clarification about any subject matter related to the Enrollee's Health Benefit Plan.

Intensive Behavioral Therapy (IBT) - Outpatient Behavioral 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 treatment program.

- For Behavioral 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 behavioral 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.

Late Enrollee - an individual who enrolls in the group subsequent to the initial enrollment period during which the individual was eligible for coverage.

Mastectomy - the surgical removal of all or part of a breast or breast tumor suspected to be malignant.

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, Behavioral Health Condition, 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 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.

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

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

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

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

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* providing 24-hour supervision,

observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Non-payment of Premium - means the failure of the named Insured to discharge any obligation in connection with the payment of Premium on a policy of commercial insurance whether the payments are payable directly to the insurer or an insurance producer or indirectly payable under a Premium finance plan or extension of credit.

On-Demand National 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.

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

Outpatient - includes but is not limited to services received from ambulatory surgery centers and Physician and anesthesia services and Benefits when applicable.

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

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

Participating Provider - a hospital or other health care entity, a practitioner or other health care professional or a health care vendor that has entered into a written agreement to provide Covered Health Care Services to our Subscribers. A Participating Provider may contract directly with us, with a Participating Medical Group, or with another Participating Provider. Participating Providers are independent contractors and are not employees of ours.

A Participating Provider includes any physician assistant, dentist, denturist, dental assistant, expanded practice dental hygienist, optometrist, clinical pharmacist, clinical social worker, nurse practitioner, pharmacist, psychologist, professional counselor, or marriage and family therapist that provide Covered Health Care Services and acts within his or her scope of practice under Oregon law. The fact that we describe a practitioner or other health professional does not mean that Covered Health Care Services from that Provider are available under the Health Plan.

Pervasive Developmental Disorder - see definition for Autism Spectrum Disorder.

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 *Osteopathic Physician* who is properly licensed by the Oregon Medical Board or the Oregon Board of Naturopathic Medicine and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, acupuncturist, naturopathic Physician, nurse practitioner, clinical social worker, clinical pharmacist, physician assistant, licensed professional counselors, licensed marriage and family therapists, denturist, expanded practice dental hygienist, 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.

Policy Year - the twelve month period beginning on the Policy effective date.

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 contractual consideration charged to an Insured for insurance for a specific period of time regardless of the timing of actual charges.

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.

"Primary care" means outpatient behavioral health services, non-specialty medical services or the coordination of health care for the purpose of:

- Promoting or maintaining behavioral and physical health and wellness; and
- Diagnosis, treatment or management of acute or chronic conditions caused by disease, injury or illness.

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

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

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

- Out-of-Network Emergency Health Care Services.

- Non-emergency Covered Health Care Services received at 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 Health 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 in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

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

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

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.

Renewal or Renew - means the issuance of, or the offer to issue by an insurer, a Policy succeeding a Policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing Policy for a specified period beyond its expiration date.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Behavioral 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.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Behavioral Health Condition or substance-related and addictive disorders, regardless of the cause or origin of the Behavioral Health Condition or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

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

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost, biotechnology drugs used to treat patients with certain illnesses.

Specified 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 Specified Dispensing Entities.

Spinal Manipulative Treatment Services (adjustment) - a form of care provided by chiropractors and osteopathic Physician 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.

Subscriber - an Eligible Employee who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment

of the disorder is a Covered Health Care Service. Substance-Related and Addictive Disorders Services means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. Substance-Related and Addictive Disorders does not include addiction to, or dependency on, tobacco, tobacco products or foods.

Supervisory Authority - the state or local corrections agency or official designated in each county by that county's board of county commissioners of county court to operate corrections supervision services, custodial facilities or both.

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.

Tobacco Use - a use of tobacco on average of four or more times per week within no longer than the past six months. This includes all tobacco products, except religious or ceremonial use of tobacco.

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

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

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

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

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor but urgent, medical conditions.

Valid, Evidence-based Sources - includes but is not limited to:

- Peer-reviewed scientific studies and medical literature;
- Recommendations of nonprofit health care provider professional associations, and;
- Specialty societies

Women's Health Care Provider - an obstetrician, gynecologist, advanced registered nurse practitioner, certified nurse midwife, or Practitioner's assistant specializing in women's health and practicing within the applicable lawful scope of practice.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits - Network and Out-of-Network

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

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

Benefits include:

- Prescription Drug Products prescribed by a Physician or clinical pharmacist to prevent conception including *Federal Drug Administration (FDA)* approved contraceptive methods such as diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives (including emergency contraceptive pills), injectable hormonal contraceptives (self-administered and/or provider administered) and Physician prescribed over-the-counter drugs as required by law. All eligible over-the-counter contraceptive drugs prescribed by a Physician that are approved by the *United States Food and Drug Administration (FDA)* are provided as a preventive Benefit at $0 cost sharing. We may use reasonable medical management techniques to control costs and promote efficient delivery of care such as covering generic drugs without cost and imposing cost sharing on equivalent Brand-name drugs. We will accommodate any person for whom a particular drug would be medically appropriate. If the Brand-name contraceptive drug with the generic equivalent is Medically Necessary, an exception for coverage without cost sharing for the Medically Necessary Brand-name contraceptive drug may be requested by your prescribing provider.

A prescription drug benefit must provide for reimbursement for up to a 90-day supply of a prescription drug dispensed by a pharmacy if:

- The prescription drug is covered by the program or plan;
- An initial 30-day supply of the prescription drug has been previously dispensed to the Covered Person; and
- The quantity of the prescription drug dispensed does not exceed the total remaining quantity of the prescription drug that the prescribing practitioner authorized to be dispensed through refills.

The coverage required by the supply limits listed above may be limited by the terms and conditions of a pharmacy network contract, or a prescription drug benefit program or health benefit plan that are related to the reimbursement rate of the prescription drug and may be limited by formulary restrictions that are related to the prescription drug.

These supply limits do not apply to the reimbursement of prescription drugs classified as a controlled substance in Schedule II and/or Specialty Prescription Drug Products.

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 in *Section 1: Covered Health Care Services* under *Pharmaceutical Products - Outpatient*.

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

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

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 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.

A prescription drug benefit must provide for reimbursement for up to a 90-day supply of a prescription drug dispensed by a pharmacy if:

- The prescription drug is covered by the program or plan;
- An initial 30-day supply of the prescription drug has been previously dispensed to the Covered Person; and
- The quantity of the prescription drug dispensed does not exceed the total remaining quantity of the prescription drug that the prescribing practitioner authorized to be dispensed through refills.

The coverage required by the supply limits listed above may be limited by the terms and conditions of a pharmacy network contract, or a prescription drug benefit program or health benefit plan that are related to the reimbursement rate of the prescription drug and may be limited by formulary restrictions that are related to the prescription drug.

These supply limits do not apply to the reimbursement of prescription drugs classified as a controlled substance in Schedule II and/or Specialty Prescription Drug Products.

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.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

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

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

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

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. If this is the case, we will work with your prescribing practitioner on the clinical criteria for the step therapy protocol. A provider may submit a medical rationale for determining that a particular step therapy is not appropriate for a particular patient based on the patient's medical condition and history.

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. 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.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
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	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. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive 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.

Payment Term And Description	Amounts
may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. Your Co-payment and/or Co-insurance for insulin, on any tier, will not exceed $80 per prescription up to a 30-day supply, regardless of the type of insulin drug prescribed for that 30-day period. For mail order, your Co-payment and/or Coinsurance for insulin, on any tier, will not exceed $160 per prescription up to a 60-day supply and $240 up to a 90-day supply, regardless of the type of insulin drug prescribed for that 60-day or 90-day period. **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.	

Payment Term And Description	Amounts
Variable Co-payment Program: Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **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 generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $30.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $60.00 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $30.00 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $60.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the

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**
adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. You may receive up to a 12-month cycle of the same contraceptive for subsequent dispensing. 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.	telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $30.00 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $60.00 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. You may receive up to a 12-month cycle of the same contraceptive for subsequent dispensing. When a Prescription Drug Product is	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $30.00 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $60.00 per Prescription Order or Refill.

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**
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 Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply	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, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $20 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $60 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $120 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**
dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	

Outpatient Prescription Drug Rider

Network/Out-of-Network

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

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

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate*.

UnitedHealthcare Insurance Company

Jessica Paik, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

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

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

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 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.

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.

Variable Co-payment Program

Certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Specialty Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty

Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

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.

Refill Synchronization

We have a procedure to align the refill dates of your prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

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

Benefits include:

- Prescription Drug Products prescribed by a Physician or clinical pharmacist to prevent conception including *Federal Drug Administration (FDA)* approved contraceptive methods such as diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives (including emergency contraceptive pills), injectable hormonal contraceptives (self-administered and/or provider administered) and Physician prescribed over-the-counter drugs as required by law. All eligible over-the-counter contraceptive drugs prescribed by a Physician that are approved by the *United States Food and Drug Administration (FDA)* are provided as a preventive Benefit at $0 cost sharing. We may use reasonable medical management techniques to control costs and promote efficient delivery of care such as covering generic drugs without cost and imposing cost sharing on equivalent Brand-name drugs. We will accommodate any person for whom a particular drug would be medically appropriate. If the Brand-name contraceptive drug with the generic equivalent is Medically Necessary, an exception for coverage without cost sharing for the Medically Necessary Brand-name contraceptive drug may be requested by your prescribing provider.

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.

Benefits for Early Refills for Prescription Eye Drops for the Treatment of Glaucoma

Benefits include one early refill of a prescription for eye drops for the treatment of glaucoma when the following criteria are met:

- The refill is requested by a Covered Person less than 30 days after the later of:
  - 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.
- The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

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, except as required for Emergency Medical Condition treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products which are prescribed for an indication not approved by the *United States Food and Drug Administration* if the Prescription Drug Product has been recognized by the *Oregon Health Resources Commission* as safe and effective for treatment of a particular indication in one or more of the following sources:
    - In publications that the *Oregon Health Resources Commission determines to be equivalent to:*
        - *The American Hospital Formulary Service Drug Information*
        - *Drug Facts and Comparisons (Lippincott Raven Publishers).*
        - *The United States Pharmacopoeia Dispensing Information, Volume 1.*
        - Other publications that have been identified by the *United States Secretary of Health and Human Services* as authoritative.
    - In the majority of relevant peer reviewed medical literature.
    - By the *United States Secretary of Health and Human Services*.
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. Any product dispensed for the purpose of appetite suppression or weight loss.
8. 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.
9. 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.
10. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.

- Vitamins with fluoride.
- Single entity vitamins.

11. Certain unit dose packaging or repackagers of Prescription Drug Products.
12. Medications used for cosmetic or convenience purposes.
13. 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.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. 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*.
16. Certain Prescription Drug Products for tobacco cessation.
17. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)
18. 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 or is an over-the-counter female contraceptive that is prescribed by the member's provider and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
19. 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.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
21. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction unless the medication is for treatment of a condition associated with a diagnosis found in the DSM-V.
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to Benefits described under *Enteral Nutrition* in *Section1: Covered Health Services* of your *Certificate of Coverage*.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to

reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. 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.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Dental products, including but not limited to prescription fluoride topicals.
29. 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.
30. Diagnostic kits and products, including associated services.
31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
32. 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. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may 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. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose meters, including continuous glucose monitors.

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with 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.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Synchronization policy - a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

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.

Care Cash Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides a description of the Care Cash program.

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

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to eligible Covered Persons.

Care Cash Program

Care Cash is a program that provides access to a prefunded debit card that may be used for certain eligible expenses as defined by the program to help with cost share obligations.

For example, an eligible expense may include certain medical expenses when you choose to seek care in a more cost-effective setting.

You can find more information about the Care Cash program by contacting us at www.myuhc.com.

UnitedHealthcare Insurance Company

Jessica Paik, President

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

Travel and Lodging Program Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides a Covered Person with a travel and lodging allowance related to the Covered Health Care Service that is not available in the Covered Person's state of residence due to law or regulation when such services are received in another state, as legally permissible.

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

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

Travel and Lodging Program

The *Travel and Lodging Program* provides support for the Covered Person under the Policy as described above. The program provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Care Service.

This program provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Care Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding the *Travel and Lodging Program*, you may contact us at www.myuhc.com or the telephone number on your identification (ID) card.

UnitedHealthcare Insurance Company

Jessica Paik, President

UnitedHealthcare Rewards Rider

UnitedHealthcare Insurance Company

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

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

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

UnitedHealthcare Rewards Program

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

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

You may receive one or more of the following:

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

Activity Targets

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

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

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

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

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

Rewards

Rewards listed above, when earned, will be credited to a or distributed in other reward types as applicable, administered by us.

Device

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

UnitedHealthcare Insurance Company

Jessica Paik, President

Virtual Behavioral Health Therapy and Coaching Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

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

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

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

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

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

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information needed to operate and manage our business activities related to providing and managing your health care

coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited

circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of

your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America;

UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited: OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: Pacific Bath Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Pacific Bath

17880 NE Airport Way

STE 110

Portland, OR 97230

(888) 408-0655

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 87-0876376

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Pacific Bath

17880 NE Airport Way

STE 110

Portland, OR 97230

(888) 408-0655

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare

185 Asylum Street

Hartford, CT 06103-0450

877-294-1429

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.