UnitedHealthcare of Arizona, Inc.

Individual Exchange Medical Policy

1 East Washington Street, Suite 1700
Phoenix, Arizona 85004
(877) 482-9045

Policy Number - [999-999-999]
Policyholder - [John Doe]
Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]
Premium Mode - [Monthly] [Quarterly]

Your *Schedule of Benefits* and *Policy* are provided in the pages that follow.

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UnitedHealthcare of Arizona, Inc.

Individual Exchange Medical Policy

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy, except that your coverage may end for events as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This Policy will renew on January 1 of each calendar year. On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product. In addition, we may make modifications at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

Nothing in this section requires us to renew or continue coverage for which your continued eligibility would otherwise be prohibited under applicable law.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

UnitedHealthcare of Arizona, Inc.



Marcus Robinson, President

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UnitedHealthcare Individual Exchange Policy

UnitedHealthcare of Arizona, Inc.

Schedule of Benefits

Covered Health Care Services Schedule of Benefits

UHC Bronze Copay Focus $0 Indiv Med Ded ($0 Virtual Urgent Care, HSA, $0 Insulin)

AZ0050, No Annual Deductible

SAMPLE

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician, who is in the Network Area and accepting new patients, in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a PCP. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and submit electronic referrals online to UnitedHealthcare for services from Network Physicians. The electronic referral must be received by UnitedHealthcare before the services are rendered. If you see a Network Physician without an electronic referral from your Primary Care Physician, you will be responsible for all charges and no Benefits will be paid, regardless of the place of service. This includes responsibility for charges for all related services and facility charges received from the Network Physician without the required referral. You should confirm what referrals have been submitted for you and the number of remaining visits on each referral by going to www.myuhc.com/exchange. You do not need a referral to see a Network obstetrician/gynecologist or to receive services through the Mental Health/Substance-Related and Addictive Disorders Delegate.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network providers through www.myuhc.com/exchange or the telephone number on your ID card.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to www.myuhc.com/exchange.

If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is in the Network Area, for that child. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that Provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. If you do not select a Network Primary Care Physician for yourself or your Enrolled Dependent child, one will be assigned.

Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from a UnitedHealthcare Individual Exchange Network provider. You can confirm that your provider is a UnitedHealthcare Individual Exchange Network provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com/exchange. You should confirm that your provider is a UnitedHealthcare Individual Exchange Network provider, including when receiving Covered Health Care Services for which you received a referral from your Primary Care Physician.

Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

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

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

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

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

You must 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, this *Schedule of Benefits* will control.

Care Management

There may be additional services that are available to you, such as disease management programs, discharge planning, health education, and patient advocacy. When you seek prior authorization for a Covered Health Care Service as required or are otherwise identified as meeting eligibility requirements for a care management program, we will work with you to engage in the care management process and to provide you with information about these additional services.

Does Prior Authorization Apply

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

Please note that prior authorization is required even if you have an electronic referral submitted online to UnitedHealthcare by your Primary Care Physician to seek care from another Network Physician.

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.

What Will You Pay for Covered Health Care Services?

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

Payment Information

Annual Deductibles are calculated on a calendar year basis.

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

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

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

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. This plan does not have a medical Annual Deductible but may have an Annual Drug Deductible. See the *Outpatient Prescription Drugs* section.	No Annual Deductible.

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Payment Term And Description	Amounts
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit 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 Drugs* section. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including the Pediatric Dental Care Services section and the *Pediatric Vision Care Services* section. 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. • Charges that exceed Allowed Amounts, when applicable.	$12,000 per Covered not to exceed $24,000 for all Covered Persons in a family.
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.	

SAMPLE

Schedule of Benefits Table

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for Benefits to be payable under this Policy.			
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 Policy, 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?**
Ambulance Services			
Emergency Ambulance Services 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*.	*Ground Ambulance:* $2,500 per transport	Yes	No
	Air Ambulance: $2,500 per transport	Yes	No
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under Allowed Amounts in this *Schedule of Benefits.*	*Ground Ambulance:* $2,500 per transport	Yes	No
	Air Ambulance: $2,500 per transport	Yes	No
Clinical Trials			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Contact Lenses for Disease or Injury			
Limited to the first pair of contact lenses for treatment of keratoconus or post-cataract surgery.	50%	Yes	No
Dental Anesthesia			

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	No
Dental Services - Accident Only			
	50%	Yes	No
Diabetes Services			
Diabetes Self-Management and Educational Services For Covered Persons with Type 1 or Type 2 diabetes, the following services are offered at $0 cost share: • Retinal eye exams, limited to 1 exam per plan year. • Preventive foot care. • Nutritional counseling. • Certain lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HbA1c) in diabetics. This does not apply to Covered Persons with pre-diabetes or gestational diabetes diagnoses.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Supplies	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management supplies will be the same as those stated under *Durable Medical Equipment (DME)* and in the *Outpatient Prescription Drugs* section. Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drugs* section.		

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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?**
Durable Medical Equipment (DME)			
You must purchase or rent the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	50%	Yes	No
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, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER Services, 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-	*Facility Services* $2,500 per visit	Yes	No
	Physician Services None	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*			
Enteral Nutrition	50%	Yes	No
Eosinophilic gastrointestinal disorder formula	25%	Yes	No
Medical foods	50%	Yes	No
Gender Dysphoria			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Habilitative Services			
	Inpatient Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Limited per year as follows: 60 visits for any combination of physical therapy, occupational therapy and speech therapy. Visit limits for therapies do not apply if the primary diagnosis code is for Mental Health, Substance Use Disorder, or Autism Spectrum Disorder.	*Outpatient* $130 per visit	Yes	No
Hearing Aids			
Limited to a single purchase per hearing impaired ear every year. Repair and/or replacement of a Hearing Aid would apply to this limit	50%	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
in the same manner as a purchase.			
Home Health Care			
Limited to 42 visits per year. Home Health Agency services that are provided in lieu of an Inpatient Stay are not subject to this limit. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider we identify.	50%	Yes	No
Hospice Care			
	50%	Yes	No
Hospital - Inpatient Stay			
	$3,000 per day, up to 3 days per Inpatient Stay	Yes	No
	Private Duty Nursing 50%	Yes	No
Lab, X-Ray and Diagnostics – Outpatient			
Lab Testing - Outpatient	$30 per service at a freestanding lab or in a Physician's office	Yes	No
	$130 per service at a Hospital-based lab	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
X-Ray and Other Diagnostic Testing - Outpatient	$130 per service at a freestanding diagnostic center or in a Physician's office	Yes	No
	$180 per service at an outpatient Hospital-based diagnostic center	Yes	No
Major Diagnostic and Imaging - Outpatient			
	$500 per service at a freestanding diagnostic center or in a Physician's office	Yes	No
	$900 per service at an outpatient Hospital-based diagnostic center	Yes	No
Manipulative Treatment			
Limited to 20 visits	$45 per visit	Yes	No
Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient (includes Residential Treatment)		
	$3,000 per day, up to 3 days per Inpatient Stay	Yes	No
	Outpatient		
	$145 per session for Intensive Outpatient Program	Yes	No
	$230 per session for Partial Hospitalization	Yes	No
	$75 per session for all other outpatient	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	services including Intensive Behavioral Therapy, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, and Psychological Testing		
	Office Visit		
	$45 per visit	Yes	No
Morbid Obesity Surgery			
Morbid Obesity surgery must be received from a Designated Provider. If you are admitted as an inpatient to a Hospital as a result of your surgery, Benefits provided as described under Hospital – Inpatient Stay and/or Physician Fees for Surgical and Medical Services may apply.	$800 per date of service at a freestanding surgical center	Yes	No
	$1,300 per date of service at an outpatient Hospital-based surgical center	Yes	No
Necessary Medical Supplies			
Compression garments for treatment of lymphedema are limited to one set upon diagnosis. Benefits are limited to four replacements per Policy year when determined Medically Necessary and the compression garment cannot be repaired or when required due to a change in your physical condition.	50%	Yes	No
Orthotics			

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	No
Pharmaceutical Products - Outpatient			
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. **Note**: Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drugs section*.	$150 per service	Yes	No
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 be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Inpatient*		
	None	Yes	No
	Outpatient		
	$400 per date of service at a freestanding center or in a Physician's office	Yes	No
	$600 per date of service at an outpatient Hospital-based center	Yes	No
Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the	$45 per visit for services provided by	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	your Primary Care Physician		
	$130 per visit for services provided by a Network Specialist	Yes	No
	50% for services provided by any other Network Physician	Yes	No
Pregnancy - Maternity Services			

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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 each Covered Health Care Service category in this *Schedule of Benefits*.		
Preventive Care Services			
Physician office services	None	N/A	No
Lab, X-ray or other preventive tests	None	N/A	No
Breast pumps	None	N/A	No
Prosthetic Devices			
Wigs and hair pieces limited to one wig or hair piece per year.	50%	Yes	No
Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: 60 visits for any combination of physical therapy, occupational therapy and speech therapy. Limits do not apply to pulmonary rehabilitation therapy and cardiac rehabilitation therapy. Visit limits for therapies do not apply if the primary diagnosis code is for Mental Health, Substance Use Disorder, or Autism Spectrum Disorder.	$130 per visit	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	50%	Yes	No
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limit will be any combination of Skilled Nursing Facility or Inpatient Rehabilitation Facility Services limited to 90 days per year.	*Skilled Nursing Facility*		
	$3,000 per day, up 3 days per Inpatient Stay	Yes	No
	Inpatient Rehabilitation Facility		
	$3,000 per day, up to 3 days per Inpatient Stay	Yes	No
Surgery - Outpatient			
	$800 per date of service at a freestanding surgical center	Yes	No
	$1,300 per date of service at an outpatient Hospital-based surgical center	Yes	No
Telehealth			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Temporomandibular Joint Syndrome (TMJ)			
	50%	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Therapeutic Treatments - Outpatient			
	Chemotherapy $750 per treatment	Yes	No
	Dialysis $500 per treatment	Yes	No
	Infusion Therapy $200 per treatment	Yes	No
	Radiation $250 per treatment	Yes	No
	All Other Treatments 50%	Yes	No
Transplantation Services			
Transplantation services must be received from a Designated Provider. Covered expenses for travel, lodging and food are limited to $10,000 per transplant. All claims filed for travel and lodging expenses must include detailed receipts, except for mileage. Mileage will be calculated based on the home address of the Covered Person and the transplant site.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Urgent Care Center Services			
Benefits include the facility charge, supplies and all professional services	*Network* $65 per visit	Yes	No

SAMPLE

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for Benefits to be payable under this Policy.			
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 Policy, 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?**
required to treat your condition in an Urgent Care setting. Benefits are available for out-of-Network Urgent Care Center services.	*Out-of-Network* $65 per visit	Yes	No
Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	*Urgent Care* None	Yes	No

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 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 this *Policy*.
- 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 this *Policy.*
- 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 this *Policy.*
- 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

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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 *Policy*.

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

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

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

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 (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

IMPORTANT NOTICE: For Ancillary Services, 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 *Policy*.

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 *Policy.*

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).*

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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 *Policy*.

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

IMPORTANT NOTICE: Out-of-Network providers may not bill you for any difference between the provider's billed charges and the Allowed Amount described here.

For Urgent Care services provided by an out-of-Network Urgent Care Center, the Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market or an amount negotiated by us and the 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/exchange 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.
- 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/exchange 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 prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in a 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.

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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 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.

Designated Providers

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

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

You or your Network Physician must notify us of special service needs (such as transplants or morbid obesity surgery) 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, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider. If you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency or if we refer you to an out-of-Network provider, we will reimburse you for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider. This means if the out-of-Network provider bills and seeks to collect from you amounts in excess of our payment, please call the telephone number on your health insurance identification card, and we will commence negotiation with the out-of-Network provider. We will not pay excessive charges or amounts that you are not legally obligated to pay. A Network exception does not include Benefits if you decide to go out-of-Network for Covered Health Care Services. Network exceptions must be arranged by us.

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Outpatient Prescription Drugs Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a 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.

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

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

How Do Supply Limits Apply?

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

Note: Some products are subject to additional supply limits 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/exchange or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician is 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 your Physician 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.

If your Physician does not obtain prior authorization from us before the Prescription Drug Product is dispensed, you will be responsible for paying all charges and no Benefits will be paid. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

If your Physician does 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. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because your Physician 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, 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/exchangeor the telephone number on your ID card.

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Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under the *Outpatient Prescription Drugs* section of the Policy are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)

When a Prescription Drug Product is not listed on the PDL, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier. Benefits for contraceptives and PrEP are covered at no cost to you.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. In the event that a Prescription Drug Product that you are currently taking moves to a higher tier or is removed from the PDL, we will notify you and your prescribing health care provider no less than 60 days prior to the change. This notice will include instructions for your provider to notify us if you should continue using the current drug for the remainder of your plan year. If your provider submits written or electronic notice that you should remain on your current medication, we will not change your coverage of that drug during the current plan year. Your provider may need to request a formulary exception for continued coverage of the drug at the time of your plan renewal.

If you are renewing the existing Health Plan coverage and have previously received approval for a Prescription Drug Product that is no longer on the PDL, you or your Physician may request an exception for continued access to the excluded Prescription Drug Product. We will approve the request if your Physician uses the exception process and submits clinical documentation showing all of the following:

- You have previously tried a Prescription Drug Product that was covered at the time and considered clinically appropriate, and it was not effective or caused a harmful or adverse reaction, specified by your Physician; and
- You have experienced a positive therapeutic outcome on the Prescription Drug Product for which you're requesting an exception for more than 90 days; and
- The available alternatives on the Prescription Drug List are contraindicated or are likely to cause a serious adverse reaction.

If your request for a formulary exception is approved, coverage for the Prescription Drug Product will remain in effect through the end of your current plan year, unless the drug is indicated for short-term use or a shorter duration is clinically appropriate. You and your prescribing Physician will receive written confirmation of the approval, including the duration of coverage. If you do not qualify for a formulary exception under the criteria outlined above, you may still request an appeal using our standard appeal process.

If we approve an exception for a Brand-name Prescription Drug Product that is not on the Prescription Drug List but has a Generic equivalent, you will also be responsible for the difference in cost between the Brand-name Prescription Drug Product and the Generic equivalent. Note: if your plan is a limited cost share American Indian plan, ancillary charges do not apply to Prescription Drug Products provided by an Indian Health Service provider, including those furnished by an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referrals under contract health services.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a Prescription Drug Product not listed on the PDL, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address

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set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization* (*IRO*) will notify you of our determination within 72 hours.

Expedited External Review

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

What Do You Pay?

You are responsible for paying the Annual Drug Deductible stated in this *Schedule of Benefits*, which is part of your Policy, before Benefits for Prescription Drug Products are available to you unless otherwise allowed under your Policy.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

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.

The Co-payment amount or Co-insurance percentage you pay for a Prescription Drug Product will not exceed the Usual and Customary Charge of the Prescription Drug Product.

The amount you pay for any of the following under your Policy may not be included in calculating any Out-of-Pocket Limit stated in your Policy:

- 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.

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Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.	$4,500 per Covered Person, not to exceed $9,000 for all Covered Persons in a family.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a 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. **Special Programs:** We may have certain programs in which you may receive a reduced 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/exchange or the telephone number on your ID card.	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. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You may obtain up to a 30-day supply of insulin products on Tier 1 at a Network Pharmacy for $0 cost to you.

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Schedule of Benefits Information Table

- Your Co-payment and/or Co-insurance is determined by Prescription Drug Products on the Prescription Drug List placed on the tiers outlined in the table below.
- Prescription Drug Products supply limit:
  - Retail Network Pharmacy – 30 or 90 days
  - Mail Order Network Pharmacy – 90 days
  - Specialty and Opioid Prescription Drug Products at a Network Pharmacy – 30 days
- Ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, not 30-day supply with three refills.
- You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.

AMOUNTS SHOWN ARE YOUR COST RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN MET			
The amounts you are required to pay as shown below are based on the Prescription Drug Charge.			
	Retail Network Pharmacy		Mail Order Network Pharmacy
	30-Day Supply	90-Day Supply	90-Day Supply
Tier 1	None Not subject to payment of the Annual Drug Deductible.	None Not subject to payment of the Annual Drug Deductible.	None Not subject to payment of the Annual Drug Deductible.
Tier 2	$15 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$37.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$37.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.
Tier 3	40% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	40% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	40% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.
Tier 4	45% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	45% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	45% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.
Tier 5	50% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	50% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.	50% of the Prescription Drug Charge. Subject to payment of the Annual Drug Deductible.

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Pediatric Dental Care Services Schedule of Benefits

How do you Access Pediatric Dental Care Services?

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental Care Services from a Network Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service that is greater than the contracted fee.

In order for Covered Dental Care Services to be paid, you must obtain all Covered Dental Care Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

Benefits are not available for Dental Care Services that are not provided by a Network Dental Provider.

Payment Information

Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Care Services and Benefits will not be payable.

Out-of-Pocket Limit - any amount you pay in Co-insurance for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

Schedule of Benefits Information Table

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Diagnostic Services	
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation. D0140 - Limited oral evaluation - problem focused. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review.	None

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D0150 - Comprehensive oral evaluation – new or established patient. D0180 - Comprehensive periodontal evaluation – new or established patient. D0160 - Detailed and extensive oral evaluation - problem focused, by report.	
Intraoral Radiographs (X-ray) Limited to 1 series of films per 36 months. D0210 - Intraoral - comprehensive series of radiographic images. D0709 - Intraoral - complete series of radiographic images - image capture only. D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images. D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only.	None
The following services are limited to 2 per 12 months. D0220 - Intraoral - periapical first radiographic image. D0230 - Intraoral - periapical - each additional radiographic image. D0240 - Intraoral - occlusal radiographic image.	None
D0374 - Intraoral tomosynthesis - periapical radiographic image. D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only. D0706 - Intraoral - occlusal radiographic image - image capture only. D0707 - Intraoral - periapical radiographic image - image capture only.	None
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single radiographic image. D0272 - Bitewings - two radiographic images. D0274 - Bitewings - four radiographic images. D0277 - Vertical bitewings – 7 to 8 radiographic images. D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images. D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only. D0708 - Intraoral - bitewing radiographic image - image capture only.	None

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image. D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only.	None
The following service is limited to two images per calendar year. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement, and analysis. D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally. D0391 - Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. D0470 - Diagnostic casts. D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services	
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis – adult. D1120 - Prophylaxis - child.	None
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish. D1208 - Topical application of fluoride - excluding varnish.	None
Sealants (Protective Coating) The following service is limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth.	None
Space Maintainers (Spacers) The following services are not subject to a frequency limit.	None

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D1510 - Space maintainer - fixed, unilateral - per quadrant. D1516 - Space maintainer - fixed – bilateral, maxillary. D1517 - Space maintainer - fixed – bilateral, mandibular. D1520 - Space maintainer - removable, unilateral - per quadrant. D1526 - Space maintainer - removable – bilateral, maxillary. D1527 - Space maintainer - removable – bilateral, mandibular. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1556 - Removal of fixed unilateral space maintainer - per quadrant. D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.	
Minor Restorative Services	
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit.* D2140 - Amalgam - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces, primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces (anterior). D2989 - Excavation of a tooth resulting in the determination of non-restorability.	
Crowns/Inlays/Onlays	
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four or more surfaces. D2610 - Inlay - porcelain/ceramic - one surface. D2620 - Inlay - porcelain/ceramic - two surfaces. D2630 - Inlay - porcelain/ceramic - three or more surfaces. D2642 - Onlay - porcelain/ceramic - two surfaces. D2643 - Onlay - porcelain/ceramic - three surfaces. D2644 - Onlay - porcelain/ceramic - four or more surfaces. D2740 - Crown - porcelain/ceramic. D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. D2753 - Crown - porcelain fused to titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2929 - Prefabricated porcelain crown - primary tooth. D2930 - Prefabricated stainless steel crown - primary tooth. D2931 - Prefabricated stainless steel crown - permanent tooth.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530- Inlay - metallic - three surfaces. D2910 - Re-cement or re-bond inlay. D2920 - Re-cement crown or re-bond inlay.	
The following services are not subject to a frequency limit. D2940 - Protective restoration.	50%
The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins when required. The following service is not subject to a frequency limit. D2951 - Pin retention - per tooth, in addition to crown.	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair necessitated by restorative material failure. D2982 - Onlay repair necessitated by restorative material failure. D2983 - Veneer repair - Onlay repair necessitated by restorative material failure.	50%
The following service is limited to one time per tooth every 36 months. D2990 - Resin infiltration of incipient smooth surface lesions.	50%
Endodontics	
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration). D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration). D3320 - Endodontic therapy, premolar tooth (excluding final restoration). D3330 - Endodontic therapy, molar tooth (excluding final restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - premolar. D3348 - Retreatment of previous root canal therapy - molar.	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement. D3353 - Apexification/recalcification - final visit.	50%
The following services are not subject to a frequency limit. D3355 - Pulpal regeneration - initial visit includes opening tooth, preparation of canal spaces, placement of medication. D3356 - Pulpal regeneration - interim medication replacement. D3357 - Pulpal regeneration - completion of treatment.	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior. D3421 - Apicoectomy - premolar (first root). D3425 - Apicoectomy - molar (first root). D3426 - Apicoectomy (each additional root). D3450 - Root amputation - per root. D3471 - Surgical repair of root resorption - anterior.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D3472 - Surgical repair of root resorption - premolar. D3473 - Surgical repair of root resorption - molar. D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier. D3920 - Hemisection (including any root removal), not including root canal therapy.	50%
Periodontics	
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. D4211 - Gingivectomy or gingivoplasty - one to three teeth contiguous or tooth bounded spaces per quadrant. D4212 - Gingivectomy or gingivoplasty - with restorative procedures, per tooth.	50%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant. D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. D4249 - Clinical crown lengthening - hard tissue.	50%
The following services are limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. D4263 - Bone replacement graft - retained natural tooth first site in quadrant. D4286 - Removal of non-resorbable barrier.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure.	50%
The following services are not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant. D4277 - Free soft tissue graft - first tooth. D4278 - Soft tissue graft procedure - each additional contiguous tooth.	50%
D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns. D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.	50%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	50%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit.	50%
The following service is limited to four times every 12 months in combination with prophylaxis D4910 - Periodontal maintenance.	50%
Removable Dentures	
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary. D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth). D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth). D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary. D5411 - Adjust complete denture - mandibular. D5421 - Adjust partial denture - maxillary. D5422 - Adjust partial denture - mandibular. D5511 - Repair broken complete denture base - mandibular.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture (each tooth). D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5621 - Repair cast partial framework - mandibular. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken retentive/clasping materials - per tooth. D5640 - Replace broken teeth - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture.	
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture. D5711 - Rebase complete mandibular denture. D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5730 - Reline complete maxillary denture (direct). D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic full denture (per arch).	50%
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%
Bridges (Fixed partial dentures)	
The following services are not subject to a frequency limit.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic – titanium and titanium alloys. D6240 - Pontic - porcelain fused to high noble metal. D6241 - Pontic - porcelain fused to predominately base metal. D6242 - Pontic - porcelain fused to noble metal. D6243 - Pontic - porcelain fused to titanium and titanium alloys. D6245 - Pontic - porcelain/ceramic.	
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis. D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	50%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic. D6750 - Retainer crown - porcelain fused to high noble metal. D6751 - Retainer crown - porcelain fused to predominately base metal. D6752 - Retainer crown - porcelain fused to noble metal. D6753 - Retainer crown - porcelain fused to titanium and titanium alloys. D6780 - Retainer crown - 3/4 cast high noble metal. D6781 - Retainer crown - 3/4 cast predominately base metal. D6782 - Retainer crown - 3/4 cast noble metal. D6783 - Retainer crown - 3/4 porcelain/ceramic. D6784 - Retainer crown - 3/4 titanium and titanium alloys. D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.	50%
The following services are not subject to a frequency limit.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6930 - Re-cement or re-bond FPD. D6980 - FPD repair necessitated by restorative material failure.	
Oral Surgery	
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root. D7210 - Surgical removal of erupted tooth requiring removal of the bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony.	50%
D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots). D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only.	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	50%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth.	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions, four or more teeth or tooth spaces - per quadrant. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible).	50%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D7510 - Incision and drainage of abscess - intraoral soft tissue. D7910 - Suture of recent small wounds up to 5 cm. D7953 - Bone replacement graft for ridge preservation - per site. D7961 - Buccal/labial frenectomy (frenulectomy). D7962 - Lingual frenectomy (frenulectomy). D7971 - Excision of pericoronal gingiva.	
The following services are limited to one every 36 months. D7921 - Collection and application of autologous blood concentrate product. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site. D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	50%
Adjunctive Services	
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain – per visit.	50%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes. D9223 - Dental sedation/general anesthesia - each 15 minute increment. D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. D9243 - Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment. D9610 - Therapeutic parenteral drug single administration.	50%
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment). D9930 - Treatment of complications (post-surgical unusual circumstances).	50%
The following are limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D9945 - Occlusal guard - soft appliance, full arch. D9946 - Occlusal guard - hard appliance, partial arch.	
Implant Procedures	
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Surgical placement of eposteal implant. D6050 - Surgical placement: transosteal implant. D6055 - Connecting bar implant or abutment supported. D6056 - Prefabricated abutment- includes modification and placement. D6057 - Custom fabricated abutment – includes placement. D6058 - Abutment supported porcelain/ceramic crown. D6059 - Abutment supported porcelain fused to metal crown (high noble metal). D6060 - Abutment supported porcelain fused to (predominately base metal). D6061 - Abutment supported porcelain fused to metal crown (noble metal). D6062 - Abutment supported cast metal crown (high noble metal). D6063 - Abutment supported cast metal crown (predominately base metal). D6064 - Abutment supported cast metal crown (noble metal). D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys. D6068 - Abutment supported retainer for porcelain/ceramic FPD. D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal). D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal). D6071 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal). D6072 - Abutment supported retainer for cast metal FPD (high noble meta).	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6073 - Abutment supported retainer for cast metal FPD (predominately base metal). D6074 - Abutment supported retainer for cast metal FPD (noble metal). D6075 - Implant supported retainer for ceramic FPD. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys. D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure. D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys. D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6089 - Accessing and retorquing loose implant screw - per screw. D6090 - Repair implant supported prosthesis, by report. D6091 - Replacement of semi - precision or precision attachment of implant/abutment supported prosthesis, per attachment. D6096 - Remove broken implant retaining screw. D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to high noble alloys. D6100 – Surgical removal of Implant removal. D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous contouring of peri-implant defect. D6103 - Bone graft for repair peri-implant defect.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6104 - Bone graft at time of implant replacement. D6105 - Removal of implant body not requiring bone removal nor flap elevation. D6110 - Implant/abutment supported removable denture for edentulous arch - maxillary. D6111 - Implant/abutment supported removable denture for edentulous arch - mandibular. D6112 - Implant/abutment supported removable denture for partially edentulous arch - maxillary. D6113 - Implant/abutment supported removable denture for partially edentulous arch - mandibular. D6114 - Implant/abutment supported fixed partial denture for edentulous arch - maxillary. D6115 - Implant/abutment supported fixed partial denture for partially edentulous arch - maxillary. D6116 - Implant/abutment supported fixed denture for partially edentulous arch - maxillary. D6117 - Implant/abutment supported fixed denture for partially edentulous arch – mandibular. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular. D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys. D6190 - Radiographic/surgical implant index, by report. D6191 - Semi-precision abutment - placement. D6192 - Semi-precision attachment - placement. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.	
D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	50%
The following services are limited to one every 36 months.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6106 - Guided tissue regeneration - resorbable barrier, per implant. D6107 - Guided tissue regeneration - non-resorbable barrier, per implant.	
Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome*, *Treacher-Collins Syndrome, Pierre-Robin Syndrome*, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8090 - Comprehensive orthodontic treatment of adult dentition. D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy. D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular. D8698 - Re-cement or re-bond fixed retainer - maxillary.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary. D8702 - Repair of fixed retainer, includes reattachment - mandibular.	

SAMPLE

Pediatric Vision Care Services Schedule of Benefits

How do you Access Pediatric Vision Care Services?

Network Benefits

Benefits - Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Network Vision Care Provider. To find a Spectera Eyecare Network Vision Care Provider, you may call the provider locator service at 1-800-638-3120. You may also access a listing of Spectera Eyecare Network Vision Care Providers on the Internet at www.myuhc.com/exchange.

Benefits are not available for Vision Care Services that are not provided by Vision Care Services from a Spectera Eyecare Network Vision Care Provider.

Payment Information

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Limit - any amount you pay in Co-insurance or Co-payments for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Schedule of Benefits Information Table

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

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	None
Eyeglass Lenses	Once every 12 months.	
• Single Vision		50%
• Bifocal		50%
• Trifocal		50%
• Lenticular		50%
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None
• Standard scratch-resistant coating	Once every 12 months.	None
• Blended segment lenses		80% of the billed charge.
• Intermediate vision lenses		80% of the billed charge.
• Standard Progressives		80% of the billed charge.
• Premium Progressives		80% of the billed charge.
• Photochromic Glass		80% of the billed charge.
• Plastic Photosensitive		80% of the billed charge.
• Polarized		80% of the billed charge.
• Hi-Index		80% of the billed charge.

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Standard Anti-Reflective Coating		80% of the billed charge.
• Premium Anti-Reflective Coating		80% of the billed charge.
• Ultra Anti-Reflective Coating		80% of the billed charge.
• UV Coating		80% of the billed charge.
• Tint		80% of the billed charge.
• Oversized Lenses		80% of the billed charge.
Eyeglass Lenses	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		50%
• Eyeglass frames with a retail cost of $130 - 160.		50%
• Eyeglass frames with a retail cost of $160 - 200.		50%
• Eyeglass frames with a retail cost of $200 - 250.		50%
• Eyeglass frames with a retail cost greater than $250.		50%
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	1 every 12 months.	None
• Covered Contact Lens Formulary	Limited to a 12 month supply.	50%
Necessary Contact Lenses	Limited to a 12 month supply.	50%
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months.	
• Low vision testing		None
• Low vision therapy		25% of billed charges.
• Low vision aids		25% of billed charges.

SAMPLE

What Is the Policy?

This Policy is a legal document between UnitedHealthcare Benefits of Texas, Inc. and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's *Application* and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's *Application*.
- Amendments

Can This Policy Change?

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

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end this *Policy*, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in Arizona. This Policy is governed by Arizona law.

SAMPLE

Introduction to Your Policy

This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Arizona, Inc.. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

How Do You Use This Document?

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

Review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this Policy 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 *Policy* and any summaries provided to you, this *Policy* 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 ID card. Throughout the document you will find statements that encourage you to contact us for more information.

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Your Responsibilities

Enrollment and Required Premiums

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

- Your enrollment must be in accordance with the requirements of this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or a Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

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

This Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services provided by Network providers. You may contact us for assistance in obtaining timely Covered Health Care Services when you or your Physician cannot find a Network provider who is timely accessible or available. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For more information on prior authorization, please refer to the *Schedule of Benefits*.

A prior authorization request, once granted or deemed granted, is binding on us, may be relied on by you and the Physician and may not be rescinded or modified by us or our utilization review agent after the Physician renders the authorized health care services in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the provider.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

SAMPLE

File Claims with Complete and Accurate Information

The Allowed Amount due to a Provider will be paid directly to the Provider except when you paid an out-of-Network provider directly for Covered Health Care Services. If you receive a Covered Health Care Service from an out-of-Network provider as a result of an Emergency or if we refer you to an out-of-Network provider, we will reimburse the out-of-Network provider for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider, as described in the *Schedule of Benefits*. In order to request payment from us, the claim must be filed 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, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract.

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Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

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

We may assign this authority to other persons or entities that may provide administrative services for this 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 this Policy.

Pay Network Providers

As described in *Section 5: How to File a Claim*, 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.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines generally in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. 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. However, if you receive a Covered Health Care Service from an out-of-Network provider, as a result of an Emergency or if we authorize services from an out-of-Network provider, we will reimburse the out-of-Network provider for any out-of-Network cost you incurred that you would not have otherwise incurred if you had received the Covered Health Care Service from a Network provider, as described in the *Schedule of Benefits*. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider at 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

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UnitedHealth Group. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

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

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 8: Defined Terms*.)
- You receive Covered Health Care Services while this Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements.
- The Covered Health Care Service is provided by or under the direction of a Physician or a provider, as defined in *Section 8: Defined Terms*.

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

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

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

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

Ambulance Services

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

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

- 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 Inpatient Rehabilitation Facility or 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:

  "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.

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Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:

  The provision of the Experimental or Investigational Service(s) or item.

  The clinically appropriate monitoring of the effects of the service or item, or

  The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
- Certain *Category B* devices. A Category B device is known to be safe and effective due to Food and Drug Administration premarket approval for that device type.

  Certain promising interventions for patients with Terminal Illnesses.

  Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

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

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

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

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- *Centers for Medicare and Medicaid Services (CMS)*.
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under this Policy.

For the purposes of this specific covered service and benefit, coverage outside the state of Arizona will be provided under the following conditions:

- The clinical trial treatment is curative in nature;
- The treatment is not available through a clinical trial in the state of Arizona;
- There is no other non-investigational treatment alternative.

Contact Lenses for Disease or Injury

Cost and fitting charge for contact lenses for the first pair of contacts for treatment of keratoconus or post-cataract surgery.

Dental Anesthesia

Covered Health Care Services include charges incurred by a Covered Person for anesthesia and facility services for hospitalization in connection with dental or oral surgery, if prior authorization has been obtained for the confinement because of a hazardous medical condition. Such hazardous medical conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, the probability of allergic reaction, or any other condition that could increase the danger of anesthesia.

Dental Services - Accident Only

Dental services when all of the following are true:

Treatment is needed because of accidental damage to sound natural teeth where the continuous course of treatment is started within six (6) months of the accident.

- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Dental services are covered for the treatment of a fractured jaw or an Injury to sound natural teeth. For the purpose of this Benefit, "sound natural teeth" are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

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

- Emergency exam.

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- 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.

Diabetes Services

Diabetes Self-Management and Training and Education Services

"Diabetes self-management training and educational services" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications, when the instruction is provided in accordance with a program in compliance with the National Standards of Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a health care professional and when provided by a certified, registered or licensed health care professional. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics including depth shoes or custom molded shoes, orthopedic shoes, inserts, modifications, footwear when Medically Necessary for the treatment of complications related to diabetes, and any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management.

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

- “Depth shoes” means the shoe has a fully length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
- “Custom molded shoes” mean constructed over a positive model of the member’s foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member’s condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

Diabetic Self-Management Supplies

Benefits for blood glucose control and testing including insulin syringes with needles, insulin preparations and glucagon, insulin cartridges, drawing up devices, blood glucose and urine test strips, lancets and lancet devices including automatic lancet devices, ketone test strips and glucose tablets, single measurement glucose monitors, including those for the legally blind, or visually impaired, certain insulin pumps, and certain continuous glucose monitors are described under the *Outpatient Prescription Drugs* section. Certain continuous glucose monitors and insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME)*. You may access a complete list of diabetic self-management supplies by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Certain diabetic supplies may be available to you at no cost when obtained through a Network Pharmacy. For more information, please refer to the Prescription Drug List, or contact us at www.myuhc.com/exchange or the telephone number on your ID card.

Durable Medical Equipment (DME)

Benefits are provided for DME. 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.

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Certain diabetic supplies may be available to you at no cost when obtained through a Network Pharmacy. For more information, please refer to the Prescription Drug List, or contact us at www.myuhc.com/exchange or the telephone number on your ID card.

DME includes, but isn't limited to:

- Canes.
- External components of, and batteries for, cochlear implants and other implantable hearing devices.
- Commode chairs.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Walkers.
- Manual wheelchairs.

Ostomy supplies are supplies which are medically appropriate for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to:

- Irrigation sleeves, bags and ostomy irrigation catheters.
- Pouches, face plates and belts.
- Pouch covers.
- Skin barriers.
- Gauze, adhesive, and adhesive remover.
- Deodorant.
- Other supplies as appropriate.

Note: Benefits are not available for filters, lubricants, tape, appliance cleaners, or other items not listed above.

Urinary catheters are covered for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to the following:

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

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

Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations.*

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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 Policy.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency whether received from a Network provider or an out-of-Network provider. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Care Services do not require prior authorization.

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).

Enteral Nutrition

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

Inherited Metabolic Disorders triggering medical food coverage are:

- Part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism;
- Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and
- Require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the Covered Person may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered Medically Necessary when you have:

- A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
- A disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

For Eosinophilic Gastrointestinal Disorder, amino acid-based formulas are considered Medically Necessary when:

- Diagnosed with eosinophilic gastrointestinal disorder.
- Under the continuous supervision of a licensed Physician.
- There is a risk of a mental or physical impairment without the use of the formula.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or Maintenance Program 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.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when the treatment is administered by any of the following

- Licensed speech-language pathologist.

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- Licensed audiologist.
- Licensed occupational therapist.
- Licensed physical therapist.
- Physician.

The following are not habilitative services:

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

We may require the following be provided:

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

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

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

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

Hearing Aids

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

Benefits are available for a Hearing Aid that is purchased through a licensed audiologist, Hearing Aid dispenser, otolaryngologist, or other authorized Provider. Benefits are provided for the Hearing Aid and associated fitting charges and testing.

The following are Covered Health Care Services:

- New or replacement Hearing Aids no longer under warranty.
- Cleaning or repair.

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

Cochlear implants are not Hearing Aids. Benefits do not include bone anchored Hearing Aids. Bone anchored Hearing Aids are a Covered Health Care Service for which Benefits are available under *Surgery – Outpatient, Physician's Office Services – Sickness and Injury*, and *Physician Fees for Surgical and Medical Services* categories in this Policy. 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.

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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 a home health aide, home health therapist, speech language pathologist, or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health Care.

For the administration of intravenous infusion, you must receive services from a Network vendor.

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

Hospice Care

Hospice care 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:

- Inpatient care.
- Outpatient services.
- Professional services of a Physician.
- Home health care services.
- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

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.

Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services which are customarily provided in acute care hospitals for an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Room and board in a private room and inpatient private duty nursing when Medically Necessary.
- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Drugs, medications, biologicals, fluids, blood and blood products.
- Chemotherapy.
- Special diets.
- Dressings and casts.
- Room and board;
- General nursing services;
- Use of operating rooms and related facilities;
- Laboratory and radiology services and other diagnostic and therapeutic services;

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- Anesthesia and associated services;
- Inhalation therapy;
- Radiation therapy; and
- Other medically necessary services and supplies furnished by the hospital during an inpatient stay.

Inpatient hospital services also include birthing centers.

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.
- 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.
- Biomarker testing, regardless of medical necessity, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions when the test provides Clinical Utility as demonstrated by medical and scientific evidence, including any of the following:
- Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration or indicated tests for a drug that is approved by the United States Food and Drug Administration.
- Centers for Medicare and Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations.
- Nationally recognized clinical practice guidelines and consensus statements.

  Benefits will be the same as those described under each Covered Health Care Service category in Section 1: Covered Health Care Services.

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

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

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, Brain Electrical Activity Mapping (BEAM), 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*.)

Manipulative Treatments

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services. Benefits include therapy to treat problems of the bones, joints, and back.

Benefits are limited as described in the Schedule of Benefits.

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of

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care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

Mental 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.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Program.
- Outpatient treatment.
- Voluntary and court-ordered residential substance abuse.

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.
- Electroconvulsive therapy (ECT).
- Inpatient and outpatient detoxification, including medical detoxification.
- Biofeedback for pain management.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA)) that are both of 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.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the *Habilitative Services and Rehabilitation Services – Outpatient Therapy* categories in this Policy.

Morbid Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician.

Necessary Medical Supplies

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump). Benefits also include Compression garments for treatment of lymphedema when determined to be Medically Necessary.

Orthotics

Orthotic devices means rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

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

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Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations*.

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.

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 Policy. Benefits for medication normally available by a prescription or order or refill are provided as described under the *Outpatient Prescription Drugs* section of this Policy.

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

Pharmaceutical Product benefits are available at a Designated Dispensing Entity or at another provider or its intermediary when they agree in writing to accept reimbursement, including copayment, at the same rate as a Designated Dispensing Entity.

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/exchange or the telephone number on your ID card.

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

Off-Label Drugs for the Treatment of Cancer

Benefits are available for drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:

- The acceptable standard medical reference compendia are the following:

  The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.

  The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.

  Thomson Micromedex Compendium DRUGDEX.

  Elsevier Gold Standard's Clinical Pharmacology Compendium.

  Other authoritative compendia as identified by the *Secretary* of the *United States Department of Health and Human Services*.

- Medical literature may be accepted if all of the following apply:

  At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

  No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the *Social Security Act* (42 United States Code section 1395x(t)(2)(B).

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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. Coverage includes Physician fees for second opinions.

Physician's Office Services – Sickness and Injury

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

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

Covered Health Care Services include:

- Genetic Counseling.
- Allergy testing and injections.
- Medical nutrition therapy provided by a licensed dietician or nutritionist, working in coordination with a Physician, to treat a chronic illness or condition.
- Diagnosis, treatment, and correction of the underlying causes of infertility. Depending on where a service is administered, Benefits will be provided under the corresponding Benefit category in this Policy.

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

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.*

Pregnancy – Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications such as treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

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 or birthing center 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.

Benefits are available for maternity-related medical, Hospital and other Covered Health Care Services for the birth of any child legally adopted by the Covered Person if all of the following are true:

- The child is adopted within one year of birth.
- The Covered Person is legally obligated to pay the costs of birth.
- The Covered Person has notified us of his or her acceptability to adopt children within 60 days after approval is received or within 60 days after a charge in health care coverage.

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

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

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the *United States Preventive Services Task Force*, including tobacco cessation interventions, annual physical exams, prostate screening, and adult routine eye exam and hearing exam during an annual physical performed by a Primary Care Physician. You can find more information at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- Prostate specific antigen (PSA) screening and digital rectal examination (DRE) covered annually if the following criteria are met:
  - You are under 40 years of age and are at high risk because of any of the following:
    - Family history (i.e., multiple first-degree relatives diagnosed at an early age).
    - Previous borderline PSA levels.
    - You are age 40 and older.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.* You can find more information at https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*, including routine eye exam during an annual physical performed by a Primary Care Physician and well-baby visits and care up to 47 months of age. You can find more information at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf or https://www.aap.org/en/practice-management/bright-futures/bright-futures-family-centered-care/well-child-visits-parent-and-patient-education.
- 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 can find more information at https://www.womenspreventivehealth.org/wellwomanchart. Benefits include:

  Screening services for breast cancer including screening mammography, a diagnostic breast exam, and a supplemental breast exam.

  For the purposes of this benefit:

  "Diagnostic breast exam" means a Medically Necessary and appropriate exam of the breast in accordance with the National Comprehensive Cancer Network guidelines and includes an exam of the breast using contrast enhanced mammography, diagnostic mammography, breast magnetic resonance imaging or breast ultrasound or molecular breast imaging, that evaluates an abnormality that is seen or suspected from a screening exam for breast cancer or detected by another means of exam.

  "Supplemental breast exam" means a Medically Necessary and appropriate exam of the breast in accordance with the National Comprehensive Cancer Network guidelines, and includes an exam of the breast using contrast enhanced mammography, breast magnetic resonance imaging or breast ultrasound or molecular breast imaging, when no abnormality is seen or suspected and the exam is based on the Covered Person’s personal or family medical history or additional factors that may increase the risk of breast cancer including heterogenous or extremely dense breasts.
- Office visits and exams (including family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).

Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).

Contraceptive device fittings, insertions and removals (e.g. IUDs, diaphragms, cervical caps).

Female sterilization methods, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure) and associated anesthesia.

- You can find more information on contraceptive services and devices at www.fda.gov/consumers/free-publications-women/birth-control-chart.
- Counseling for breastfeeding/lactation, genetic, nutrition, obesity in adults and children, sexually transmitted infections, domestic violence, skin cancer, and tobacco use.
- HIV pre-exposure prophylaxis (PrEP) and related services.

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Benefits for contraceptives as described in this benefit and PrEP are covered at no cost share to you. If a Prescription Drug Product for contraceptives or PrEP is not included on the Prescription Drug List (PDL), you can find more information on how to request an exception as described under *Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)* under the *Outpatient Prescription Drugs Schedule of Benefits*.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. This Benefit includes a personal-use electric breast pump, including a double electric pump. Breast pumps must be ordered by or provided by a Physician. You will not be reimbursed for a breast pump purchased at a retail store. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Prosthetic Devices

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

- Artificial arms, legs and feet.
- Terminal devices such as a hand or hook.
- 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.
- Wigs.

Internal prosthetic and/or medical appliances are prosthetics and appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following Medically Necessary surgical removal of the testicles. Covered Health Care Services include Medically Necessary repair, maintenance or replacement of a covered appliance.

Covered Health Care Services also include wigs or hairpieces for hair loss as a result of chemotherapy, radiation therapy, or second- or third-degree burns. The covered person must provide a valid prescription order verifying diagnosis of hair loss as a result of chemotherapy, radiation therapy, or second-or third-degree burns along with the claim submitted for coverage.

Maintenance and replacement of artificial arms and legs and terminal devices are Covered Health Care Services if necessitated by normal anatomical growth or as a result of wear and tear. The following are specifically excluded:

- Any biomechanical devices. Biomechanical devices are any external prosthetics operated through or in conjunction with nerve conduction or other electrical impulses;
- Replacement of external prosthetic appliances due to loss or theft; and
- Wigs or hairpieces, except as described above.

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

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

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

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, accidental Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Microtia repair, Medically Necessary treatment for blepharoplasty (upper lid) or sclerotherapy are considered reconstructive procedures.

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Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications such as lymphedemas during all stages of a mastectomy, 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.

Rehabilitation Services – Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

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

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits 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*.

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.

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*.

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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 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.

Surgery – Outpatient

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

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services, including the professional services of your surgeon are described under Physician Fees for Surgical and Medical Services.)
- Voluntary male sterilization and associated anesthesia.
- Cataract surgery with a standard intraocular lens
- Surgical implantation of cochlear implants or other implantable hearing devices when you have either of the following:

Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable Hearing Aid.

A diagnosis of Sensorineural Hearing Loss, or SNHL, where there is no damage to the inner ear or to the nerve pathways from the inner ear to the brain.

- Therapeutic surgical abortion recommended by a Provider and performed to save the life of the mother or as a result of incest or rape. Depending on where a non-surgical abortion is administered, Benefits will be provided for under the corresponding Benefit category in this Policy.

Tissue transplants and cornea transplants when ordered by a Physician. Benefits are available for tissue and cornea transplants when the transplant meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or unproven service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

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Telehealth

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

Telehealth/Telemedicine – live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider. Your cost sharing may be different for services delivered via Telehealth/Telemedicine as compared to Virtual Care Services provided by a Designated Virtual Network Provider. Please reference the *Schedule of Benefits* to see the cost sharing associated with each of these benefits. Telehealth/Telemedicine includes the use of an audio-only telephone encounter between a Physician and patient if an audio with visual transmission encounter is not reasonably available due to your preference, functional status, lack of technology or telecommunications infrastructure limits as determined by the Physician, except for procedure or services for which the weight of evidence, based on peer-reviewed clinical publications or research, recommends not be provided through telehealth.

Temporomandibular Joint Syndrome (TMJ)

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders when treatment is needed for:

- Accidental damage.
- Trauma.
- Congenital Anomaly.
- Developmental defect.
- Pathology.
- Orthognathic surgery.

Benefits include services for diagnostic and surgical treatment that is recognized by us as a generally accepted form of care or treatment, according to prevailing standards of the medical and dental practice profession as effective and appropriate for the diagnosis and surgical treatment of temporomandibular joint and craniomandibular disorders.

Benefits for non-surgical treatment of temporomandibular joint and craniomandibular disorders include intra-oral splints that stabilize or reposition the jaw joint.

Benefits do not include charges that are incurred for any service related to fixed or removable appliances that involve movement or repositioning of the teeth, occlusal (bite) adjustments, treatment of malocclusion, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures, dental implants).

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.

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*.

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Transplantation Services

Organ transplants, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service received from a Designated Provider.

Examples of transplants for which Benefits are available include:

- Bone marrow/stem cell.
- Cornea.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

Benefits for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Benefits are available for travel, lodging, and food for the Covered Person and one companion due to evaluation, candidacy, transplant event, and post-transplant care. All claims filed for travel expenses must include detailed receipts, except for milage. Mileage will be calculated based on the home address of the Covered person and the transplant site. Travel expenses for both rental and personal vehicles are reimbursed on a mileage basis only. The reimbursement is the same regardless of whether it be a rental vehicle or personal vehicle.

Organ transplant travel benefits are not available for cornea transplants.

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

Urgent Care Center Services

Covered Health Care Services received at a Network or out-of-Network Urgent Care Center. 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*.

Virtual Care Services

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

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

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

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

Benefits do not include email or fax, or for services that occur within medical facilities (*CMS* defined originating facilities). Your cost sharing may be different for services delivered via Telehealth/Telemedicine as compared to

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Virtual Care Services provided by a Designated Virtual Network Provider. Please reference the Schedule of Benefits to see the cost sharing associated with each of these benefits.

SAMPLE

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Other forms of alternative treatment This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays and other imaging studies, 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 provided as described under *Dental Services – Accident Only in Section 1: Covered Health Care Services*.

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

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of cancer or cleft palate.
   - Dental anesthesia for which Benefits are provided as described under Dental Anesthesia in Section 1: *Covered Health Care Services*.

SAMPLE

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 does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* or *Temporomandibular Joint Syndrome (TMJ)* in *Section 1: Covered Health Care Services*.
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only in Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

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 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 *Diabetes Services,* and *Durable Medical Equipment DME),* and *Orthotics,* 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.
    - Transport chairs. Examples of transport chairs include:
        - Powered walker including enhancement accessories of walkers.
        - Combination wheeled walker with seat and transport chair.
4. Devices and computers to help in communication and speech.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Wigs, except for which Benefits are described under *Prosthetic Devices* in *Section 1: Covered Health Care Services*.
10. Powered wheelchairs.

SAMPLE

Drugs

1. Prescription drug products for outpatient use that are (1) not administered in a Hospital, Alternate Facility, Physician's office, or in your home and (2) filled by a Prescription Order or Refill. See the *Outpatient Prescription Drugs* section of this Policy for covered Prescription Drug Products.
2. Self-administered or self-infused medications that are covered under the *Outpatient Prescription Drugs* section of this Policy. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments..
5. 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 of condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
6. 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 monthly.
7. 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 monthly.
8. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to monthly.
9. 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 monthly.
10. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational Services

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

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

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.

SAMPLE

2. Treatment of flat feet.
3. Treatment of subluxation of the foot. This exclusion does not apply to physical therapy to treat this condition.
4. Foot orthotics, orthopedic shoes, inserts, modifications, and footwear except as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Arch supports. This does not include Benefits found under *Diabetes Services* in *Section 1: Covered Health Care Services.*

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
    - Compression stockings. This does not include compression garments for lymphedema for which benefits may be found under Necessary Medical Supplies in Section 1: Covered Health Care Services.
    - Ace bandages.
    - Items routinely found in the home.

    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) and Prosthetic Devices* in *Section 1: Covered Health Care Services.*
    - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Tubings except when used with DME as described under *Necessary Medical 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.

Nutrition

1. 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*.
2. Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist, or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.
3. Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as listed in the benefit plan.

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. This exclusion does not apply to batteries for cochlear implants.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.

SAMPLE

- 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.

Physical Appearance

1. Cosmetic Procedures when not determined to be Medically Necessary. See the definition in *Section 8: Defined Terms*. Examples include:
    - Membership costs and fees for health clubs and gyms. This exclusion does not apply to incentives provided as described under the heading Are Incentives Available to You? In Section 7: General Legal Provisions.
    - 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.
    - Hair removal or replacement by any means.
    - Abdominoplasty.
    - Body contouring, such as lipoplasty.

SAMPLE

- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

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

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Medically Necessary panniculectomy.
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. 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.
6. Biofeedback, except as described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.
7. The following services for the diagnosis and treatment of Temporomandibular Joint Syndrome (TMJ): surface electromyography; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
8. Breast reduction and augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine treats a physiologic functional impairment 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.*

SAMPLE

9. Helicobacter pylori *(H. pylori)* serologic testing.
10. Intracellular micronutrient testing
11. Obesity - weight loss surgery not received at a Designated Provider.
12. Sex transformation surgery, including medical and hormonal therapy in preparation for and subsequent to any such surgery is excluded.

Providers

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

- Has not been 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.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services performed for the diagnosis and treatment of any underlying cause of infertility as described under *Physician's Office Services – Sickness and Injury* in *Section 1: Covered Health Care Services*. Benefits for diagnostic testing for use in diagnosing infertility are covered the same as those for testing related to any other disease or condition.
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).
- 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. This exclusion does not apply to benefits available under the Pregnancy – Maternity Services provision for the birth of a child legally adopted by a Covered Person when the conditions of A.R.S. § 20-1057(K) are satisfied, including when the Covered Person is legally obligated to pay the costs of birth.
- 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.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat sexual dysfunction and/or impotency.

SAMPLE

8. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to Benefits as described under *Surgery – Outpatient* in *Section 1: Covered Health Care Services*.

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. Examples include coverage required by workers' compensation, or similar legislation.

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

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

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* and/or *Surgery – Outpatient 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 this Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider.

Travel

1. Health care services provided in a foreign country.
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.*

Types of Care, Supportive Services, and Housing

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing. This exclusion does not apply to inpatient Private Duty Nursing for which Benefits are provided as described under *Hospital - Inpatient Stay* in *Section 1: Covered Health Care Services*.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
5. Rest cures.
6. Services of Personal Care Aides.
7. Independent living services.
8. Assisted living services.
9. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act*.
10. Vocational counseling, testing and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).

SAMPLE

11. Transitional Living services (including recovery residences).

Unproven Services

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

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to contact lenses or scleral shells that are used to therapeutically treat an injury or disease (such as corneal abrasion, keratoconus or severe dry eye). This exclusion does not apply to services for which Benefits are provided as described under Contact Lenses for Disease or Injury or under Section 11: Pediatric Vision Care Services.
2. Routine vision exams not performed by a Primary Care Physician, including refractive exams to determine the need for vision correction. This exclusion does not apply to Benefits as described under *Section 11: Pediatric Vision Care Services*.
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. Over-the-counter Hearing Aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
    - Medically Necessary.
    - Described as a Covered Health Care Service in this Policy under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this *Policy* 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 this *Policy* when:
    - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
    - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under this Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under this Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under this Policy.

SAMPLE

6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long-term storage:
    - Long-term storage services are not a Covered Health Care Service.
    - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a member is entering the military, etc., we will not cover any long-term storage of the above.
    - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
9. Autopsy.
10. Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
12. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).
13. Blood or tissue typing for paternity testing are not a covered service.
14. Specimen Provenance testing are not a covered service.
15. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the benefit plan.
16. Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.
17. Stand-by availability of a medical practitioner when no treatment is rendered.
18. Services or supplies that are provided prior to the effective date or after the termination date of this Policy.

SAMPLE

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the federal Health Insurance Marketplace. 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 this 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. Network Benefits are available only if you receive Covered Health Care Services from Network providers.

Who Is Eligible for Coverage?

The federal Health Insurance Marketplace determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the federal Health Insurance Marketplace. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the federal Health Insurance Marketplace.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When Do You Enroll and When Does Coverage Begin?

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

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the federal Health Insurance Marketplace.

Coverage begins on the date determined by the federal Health Insurance Marketplace and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the federal Health Insurance Marketplace.

For the purpose of this provision, a “qualified individual“ is an individual who has been determined eligible to enroll in a Qualified Health Plan through the federal Health Insurance Marketplace.

The federal Health Insurance Marketplace will allow qualified individuals or Dependents to enroll in or change from one Qualified Health Plan to another as a result of the following triggering events:

SAMPLE

- Loss of minimum essential coverage.

  Loss of minimum essential coverage does not include loss due to:

Failure to pay Premiums on a timely basis, including COBRA premium prior to the expiration of COBRA coverage;

Situations allowing for rescission of coverage (the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact); or

Voluntary termination.

- End of policy year for a qualified individual covered under a non-calendar year group health plan, individual health insurance plan, or qualified small employer health reimbursement arrangement (QSEHRA), even if an individual or Dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.
- Loss of pregnancy related coverage by a qualified individual or Dependent under the *Social Security Act (Medicaid)* or loss of access to health care services through coverage provided to a pregnant woman's unborn child.
- Loss of medically needy coverage as described under the *Social Security Act* only once per calendar year.
- A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. In the case of marriage, at least one spouse must demonstrate having coverage (as described further below) for one or more days during the 60 days preceding the date of the marriage.
- A qualified individual's or Dependent's enrollment or non-enrollment in a Qualified Health Plan is, as evaluated and determined by the federal Health Insurance Marketplace:

Unintentional, inadvertent, or erroneous; and

The result of the error, misrepresentations, misconduct, or inaction of an officer, employee, or agent of the federal Health Insurance Marketplace or the *U.S. Department of Health and Human Services (HHS)* or its instrumentalities, or a non-Health Insurance Marketplace entity;

  In these circumstances, the federal Health Insurance Marketplace may take action as may be necessary to correct or eliminate the effects of the error, misrepresentation, misconduct, or inaction.

- A qualified individual or Dependent adequately demonstrates to the federal Health Insurance Marketplace that the Qualified Health Plan in which the individual or Dependent is enrolled substantially violated a material provision of the Qualified Health Plan's contract in relation to the individual or Dependent.
- A qualified individual or Dependent adequately demonstrates to the federal Health Insurance Marketplace that a material error related to plan benefits, service area, or premium influenced the qualified individual's decision to purchase a Qualified Health Plan through the federal Health Insurance Marketplace.
- A qualified individual or Dependent is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, including;

A qualified individual's Dependent enrolled in the same Qualified Health Plan is determined newly eligible or newly ineligible for advance payments of the premium tax credit has a change in eligibility for cost-sharing reductions;

A qualified individual or Dependent newly eligible for cost-sharing reductions and not enrolled in a silver-level Qualified Health Plan may enroll only in a silver-level Qualified Health Plan.

A qualified individual or Dependent newly ineligible for cost-sharing reductions and enrolled in a silver-level Qualified Health Plan may enroll in a Qualified Health Plan one level higher or lower.

A qualified individual or Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

A qualified individual or Dependent who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100% of the federal poverty level and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the qualified individual becoming eligible for advance payments of the premium tax credit.

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- A qualified individual or Dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).
- A qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the federal Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 CFR 155.315 or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.
- A qualified individual or Dependent gains access to a new Qualified Health Plan as a result of a permanent move and can demonstrate having coverage for one or more days in the 60 days preceding the date of the move (as described further below).
- A qualified individual or Dependent who was not previously a citizen, national, or lawfully present individual becomes a citizen, national, or lawfully present individual.
- A qualified individual or Dependent demonstrates to the federal Health Insurance Marketplace, in accordance with guidelines issued by the *HHS*, that the qualified individual meets other exceptional circumstances as the federal Health Insurance Marketplace may provide. For purposes of this triggering event, a qualified individual or Dependent may enroll in or change to any Qualified Health Plan, regardless of whether the qualified individual or Dependent is currently enrolled in a Qualified Health Plan.
- An Indian, as defined by the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.
- A qualified individual loses a Dependent or is no longer a Dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the qualified individual or Dependent, dies.
- A qualified individual is a victim of domestic abuse or spousal abandonment or a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment.
- A qualified individual applies for coverage on the federal Health Insurance Marketplace during the annual open enrollment period or due to a qualifying event, is assessed by the federal Health Insurance Marketplace as potentially eligible for Medicaid or for the Children's Health Insurance Program (CHIP) and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event.

Qualified individuals who are required to demonstrate having coverage in the 60 days prior to a triggering event can do so by demonstrating:

- They had minimum essential coverage for one or more days during the 60 days preceding the date of the triggering event;
- They had pregnancy related coverage or access to healthcare services through unborn child coverage;
- They had medically needy coverage;
- They are an Indian, as defined by the Indian Health Care Improvement Act;
- They lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or
- For one or more days during the 60 days preceding the triggering event or during their most recent preceding open enrollment or special enrollment period, lived in a service area where no Qualified Health Plan was available through the federal Health Insurance Marketplace.

Length of Special Enrollment Periods:

- Unless stated otherwise in this section, a qualified individual or Dependent has 60 days from the date of the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent who: 1) loses minimum essential coverage; 2) is enrolled under a non-calendar year group health plan or individual health insurance plan; 3) loses pregnancy related coverage by a qualified individual under the *Social Security Act (Medicaid*), or 4) loses medically needy coverage as described

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under the *Social Security Act* only once per calendar year, has 60 days before and after loss of coverage to select a Qualified Health Plan.

A qualified individual or Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage has 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a Qualified Health Plan.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the federal Health Insurance Marketplace.

The Policyholder must notify federal Health Insurance Marketplace of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow federal Health Insurance Marketplace rules. See https://www.healthcare.gov/coverage-outside-open-enrollment/confirm-special-enrollment-period/. Additional Premium may also be required, and it will be calculated from the date determined by federal Health Insurance Marketplace.

NOTE. Subject to a determination of federal Health Insurance Marketplace, an eligible child born to you or your spouse will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for loss due to Injury and Sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act.*
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which your coverage becomes effective.

Misstatement of Age or Tobacco Use

If your age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify federal Health Insurance Marketplace of your new residence. Your Premium will be based on your new residence beginning on the date determined by federal Health Insurance Marketplace. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Care Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

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However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under *section 36B of title 26*, as provided for by the *Patient Protection and Affordable Care Act (PPACA),* you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Care Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

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Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

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

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if any of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by you or with your knowledge in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.
- Your eligibility would otherwise be prohibited under applicable law.

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 this Policy ends. That date will be one of the following:

The date determined by the federal Health Insurance Marketplace that this Policy will terminate because the Policyholder no longer lives in the Service Area.

The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.

The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be a Policyholder or an Enrolled Dependent, as determined by the federal Health Insurance Marketplace. Please refer to *Section 8: Defined Terms* for definitions of the terms “Eligible Person,” “Policyholder,” "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the date determined by the federal Health Insurance Marketplace rules if we receive notice from the federal Health Insurance Marketplace instructing us to end your coverage.

Your coverage ends on the date determined by the federal Health Insurance Marketplace rules if we receive notice from you instructing us to end your coverage.

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Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

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

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

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

Coverage for a Disabled Dependent Child

Coverage for an 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 mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Policyholder 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 this 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 26 years of 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.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the federal Health Insurance Marketplace.

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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.

Required Information

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

- The Policyholder'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:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Payment of Claims

Time for Payment of Claim

Benefits will be paid within 30 days after we receive all of the required information listed above.

Assignment of Benefits

You may not assign your Benefits under this Policy or any cause of action related to your Benefits under this Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Policyholder 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 over 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 this Policy to an out-of-Network provider with our consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

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

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

Payment of Benefits under the Policy shall be made in the form of cash, check, or electronic funds transfer, or in a form of other consideration that we determine to be adequate. When an assignment of Benefits is obtained and

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Benefits are payable directly to a provider, we may consider forgiving, in whole or in part, the amount the provider owes us, or to other plans where we have taken an assignment of the other plans' recovery rights for value.

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Section 6: Questions, Complaints and Appeals

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

You may write a letter or submit your request electronically on myuhc.com. If someone other than yourself is submitting on your behalf, you must authorize the representative in writing.

You may also refer to the telephone number shown on your ID card. Representatives are available to take your call during local business hours, Monday through Friday.

To send your letter to us, our address is:

Medical Appeal	UnitedHealthcare Appeals & Complaints PO Box 6111 Mail Stop CA-0197 Cypress, CA 90630
Prescription Drug Appeal	OptumRx c/o Appeals Coordinator PO Box 2975 Mission, KS 66201

What if You Have a Question?

Our Customer Service Representatives are trained to answer your questions about your health benefit plan including but not limited to:

- Your coverage and Benefit levels, including Co-insurance and Co-payment amounts.
- Specific claims or services you have received.
- Doctors or Hospitals in the Network.
- Referral processes or authorizations.
- Provider directories.

What if You Have a Complaint or Appeal

A complaint is an expression of dissatisfaction.

An appeal is a request to review a decision that denies a benefit or payment.

You may write to us to file a complaint about quality of service and quality of care that you received.

We will notify you of our decision regarding your complaint within 60 business days of receiving it.

If someone other than yourself is submitting the complaint on your behalf, you must authorize the representative by:

- Logging into your www.myuhc.com/exchanges account>My Account>Account Settings>Personal Representative Management; or
- Filling out a Designation of Authorized Representative form and submitting it with your appeal or complaint request. This form can be found at the back of the Arizona Appeals Information Packet or https://cms.member.myuhc.com/content/dam/myuhc/consumer/assests/pdf/consumer/claims/document-center/designation_of_authorization.pdf.

How Do You Appeal a Decision?

Appeals and Complaint Process: You may participate in our appeals and complaint process. Our appeals and complaint process is explained in detail in the Arizona Appeals Information Packet. The Arizona Appeals Information Packet will be provided to you as follows:

- Upon Initial Application: A copy of the Arizona Appeals Information Packet will be attached to your policy upon initial application.
- When Your Health Plan Coverage is Renewed: When your coverage under the policy is renewed, we will send you a separate statement with your policy to remind you that you can request to receive another copy of the Arizona Appeals Information Packet by contacting Customer Care at the telephone number on your ID card.

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- Upon Your Request or Your Treating Provider's Request: You or your treating provider may obtain a copy of the Arizona Appeals Information Packet at any time by calling the telephone number on your ID card or our website at https://www.uhc.com/legal/required-state-notices/arizona.

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Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We administer this Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the 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 Policy.
- 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?

We have agreements in place that govern the relationship between us and Network providers, some of which are affiliated providers. Network providers enter into an agreement 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.

What Is Your Relationship with Providers?

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.

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.

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- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your 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 your *Schedule of Benefits*.

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

Are Incentives Available to You?

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

As determined by us, incentives may include, but are not limited to, the following:

- A digital fitness program.
- Rewards card incentives valued at a maximum of $500 for completing certain activities throughout the year, such as having a wellness visit with your Primary Care Physician or taking other plan communication-related actions (e.g., signing up for text messages or paperless communications).

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. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

We have the sole and exclusive authority to do all of the following:

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

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

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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 this Policy

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end this Policy.

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

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

- Amendments to this Policy are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

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Is Workers' Compensation Affected?

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

Important Notice – Third-Party Payers

When there is a third-party source of payment such as liability insurer, a government payer, or any uninsured and/or underinsured motorist coverage, Network providers may be entitled to collect from the third parties. They may be entitled to collect any difference between the Allowed Amount that we pay and the Network providers' customary charges, pursuant to A.R.S. 33-931. Arizona law prohibits providers from charging you more than the Co-payment and any deductible you are required to pay as described in this Certificate of Coverage.

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 this 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 this Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

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?

This Policy, the *Schedule of Benefits*, the Policyholder's *Application* and any Amendments, make up the entire Policy.

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Section 8: Defined Terms

Air Ambulance - medical transport by helicopter or airplane.

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 generally in accordance with one or more of the following methodologies:

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

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

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

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

Alternative Treatments - medical systems or practices used in place of conventional medicine, including homeopathy, naturopathy, Ayurvedic medicine, and traditional Chinese medicine

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:

- Emergency medicine;
- Anesthesiology;
- Pathology;
- Radiology;
- Neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services;
- Provided by an out-of-Network Physician when no other Network Physician is available.

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

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

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

SAMPLE

Chemotherapy - charges incurred for the treatment of disease by chemical or biological antineoplastic agents or related supportive care regimens administered orally, intravenously or by injection. The chemical or biological antineoplastic agents or related supportive care regimens may be administered during a doctor's visit, home health care visit, or at an outpatient facility.

Clinical Utility - the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

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

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

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

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

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

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

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

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

Covered Person - the Policyholder or a Dependent, but this term applies only while the person is enrolled under this Policy. We use "you" and "your" in this Policy 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 - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. 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 Policyholder or the Policyholder's spouse.

The following conditions apply:

- A Dependent includes a child listed above and under age 26.

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

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

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

Designated 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 Service 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/exchange or the telephone number on your ID card.

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

Dialysis - the process in which waste products are removed from the body by diffusion from one fluid compartment to another through a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis.

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

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

Eligible Person - a person who meets the eligibility requirements determined by the federal Health Insurance Marketplace. An Eligible Person must live within the Service Area.

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

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

Emergency Health Care Services - with respect to an Emergency:

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

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

- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

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

  e) Any other conditions as specified by the Secretary.

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

- Emergency Health Care Services do not require prior authorization.

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

Eosinophilic Gastrointestinal Disorder Formula - amino acid-based formula used in the treatment of a Covered Person who has been diagnosed as having an eosinophilic gastrointestinal disorder, subject to the following conditions:

- The Covered Person must be under the continuous supervision of a Physician who is licensed under Title 32, Chapter 13 or 17 of the *Arizona Revised Statutes* or a registered nurse practitioner who is licensed under Title 32, Chapter 15 of the *Arizona Revised Statutes*.
- The formula must be prescribed or ordered by a Physician or a registered nurse practitioner.
- There must be a risk of mental or physical impairment to the Covered Person without the use of the formula.

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:

AHFS Drug Information (AHFS DI) under therapeutic uses section;

Elsevier Gold Standard's Clinical pharmacology under the indications section;

DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or

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

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

SAMPLE

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 the service has significant potential as an effective treatment for that Sickness or condition.

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

Functional or Physical Impairment - a Functional or Physical or Physiological Impairment which causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks;
- independent movement;
- performing basic life functions.

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.

Habilitative Services - Skilled Care services that are part of a prescribed treatment plan or Maintenance Program 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.

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S.*

SAMPLE

Food and Drug Administration (FDA) as Hearing Aids. Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of this Policy, they are Hearing Aids).

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

Home Health Care Services - 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.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the Home Health Care.

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

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

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

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

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.

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients.

Inherited Metabolic Disorder - a disease or disorder caused by an inherited abnormality of body chemistry, including a disease or disorder tested under the newborn screening program:

- Which involves amnio acid, carbohydrate and fat metabolism.
- For which medically standard methods of diagnosis, treatment, and monitoring exist.
- Which requires specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or a registered nurse practitioner with special training in the diagnosis and treatment of patients with genetic inborn errors of metabolism and that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

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

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

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

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

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

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Intensive Outpatient Program - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

Maintenance Program - A program with the goals to maintain the functional status or to prevent decline in function.

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

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

Medical Foods - modified nutritional substances in any form that are all of the following:

- Used for the treatment of Inherited Metabolic Disorders to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- Formulated to be consumed or administered enterally under the supervision of a Physician or a registered nurse practitioner.
- Specifically processed or formulated to be deficient in one or more nutrients present in typical foodstuffs. This does not include a natural food or food product that is naturally low in protein.
- Intended for the medical and nutritional management of patients who have limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health, and metabolic homeostasis.

Medically Necessary - health care services, that are all of the following as determined by us or our designee.

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

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

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered

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Persons through www.myuhc.com/exchange or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

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

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

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

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

Morbid Obesity Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity.

Necessary Medical Supplies - medical supplies that are used in the home with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

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 Area - the Service Area, supplemented by any additional providers we include as Network Area providers. Contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information on the Network Area.

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, new dosage form, or new indication of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product, new dosage form, or new indication is commercially available following approval 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.

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 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 how the Out-of-Pocket Limit applies.

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

Personal Care Aide - an individual who assist Covered Persons in everyday tasks. They may also monitor a Covered Persons disability or chronic illness and help with daily living activities.

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- *Schedule of Benefits*.
- Policyholder *Application*.
- Amendments.

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

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Pregnancy - includes all of the following:

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

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

Presumptive Drug Test - qualitative test to determine the presence or absence of drugs or a drug class with results indicating a negative or positive result.

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

Private Duty Nursing - A provision of continuous Skilled Care from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in an individual's residence by a Home Health Agency, under the direction of the patient's Physician.

Private Room - private room accommodations means a Hospital room containing one bed.

Provider - A licensed participating provider who is contracted to provide medical services to Covered Persons (as defined within the provider contract). The provider may be a Hospital, pharmacy, other facility or a Physician or health care professional who has contractually accepted the terms and conditions as set forth.

Psychiatric Service - psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of mental or emotional disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be medically appropriate.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from federal Health Insurance Marketplace.

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

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision,

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"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.

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.

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

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

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

Rehabilitation - health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

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 professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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

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

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

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

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

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency.

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.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness or substance-related and addictive disorders.

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

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- 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. This does not include a facility primarily for rest, the aged, treatment of Substance-Related and Addictive Disorders Services, or for care of behavioral health disorders.

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

Sub-Acute Facility - means a facility that provides intermediate care on short-term or long-term basis.

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 Mental Disorders* published by 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 Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Temporomandibular Joint Syndrome (TMJ) - Temporomandibular joint and muscle disorders are a collective group of conditions and symptoms characterized by pain and dysfunction to the temporomandibular joint and/or surrounding muscles that control jaw movement. Symptoms often include pain or tenderness to the temporomandibular joint, ear, neck, back, or shoulder, limited jaw mobility, or audible sounds with jaw movement.

Terminal Illness - in the context of hospice means a life expectancy, certified by a Physician, of six months or less.

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

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

Urgent Care - Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent Care is usually delivered in a walk-in setting and without an appointment. Urgent Care facilities are a location, distinct from a hospital Emergency Department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms. Urgent Care facilities are a location, distinct from a hospital Emergency Department, an office or a clinic.

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Section 9: Outpatient Prescription Drugs

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List Management Committee (PDL MC) makes tier placement changes on our behalf. The PDL MC places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic information. 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.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen up to monthly. These changes may happen without prior notice to you. In the event that a Prescription Drug Product that you are currently taking moves to a higher tier or is removed from the PDL, we will notify you no less than 30 days prior to the change. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card for the most up-to-date tier placement.

When considering a Prescription Drug Product for tier placement, the PDL MC 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: Tier status for a Prescription Drug Product may be determined by accessing your Benefits for Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. The tier to which a Prescription Drug Product is assigned may change as detailed in the Policy.

Prescription Drug Products that are considered to be PPACA Zero Cost Share Preventive Care Medications will be provided at $0 cost share for Covered Persons.

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 Policy 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:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

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 choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may not have coverage.

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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.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced 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/exchange or the telephone number on your ID card.

Are Discounts and Incentives Available to You?

From time to time, we may make access available to discounts or incentive programs. Incentive programs may be available only to targeted populations and may include other incentives.

These discount and incentive programs are not insurance and are not an insurance benefit or promise in the Policy. Your access to these programs is provided by us separately or independently from the Policy and may be discontinued at any time. There is no additional charge for you to access these discount and incentive programs.

These programs may be offered or administered directly by us or through a third-party vendor. If we receive any funds from a third-party vendor in conjunction with making the discount or incentive programs available to you, we will use those funds to offset our costs of providing you access to the programs.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance and/or any applicable deductible 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, Co-insurance and/or any applicable deductible requirements.

- Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.
- Benefits are available for Tretinoin for Covered Persons when used to treat acne or other skin diseases as determined by your Physician.
- Benefits are available for growth hormones for Covered Person under Outpatient Prescription Drugs with prior authorization.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You should work with your pharmacy to coordinate prescription refills.

We will not deny coverage and will prorate the cost sharing rate for a covered Prescription Drug Product by the evidence of coverage that is dispensed by a Network Pharmacy for less than the standard refill amount if you request enrollment into a medication synchronization program and less than the standard refill amount for the purpose of synchronizing your medication.

We will accept early refill and short fill requests for Prescription Drug Products using the submission clarification and message codes as adopted by the national council for prescription drug plans or alternative codes by the plan.

SAMPLE

For the purpose of this Benefit the following term has the following meaning “medication synchronization” means the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single contracted pharmacy to facilitate the synchronization of the patient’s medications for the purpose of improving medication adherence.

Benefits for Oral Chemotherapeutic Agents

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

Benefits for Refills for Prescription Eye Drops to Treat Glaucoma or Ocular Hypertension

Benefits include refills of a prescription for eye drops to treat glaucoma or ocular hypertension if the following apply:

- You request the refill:
- For a 30-day supply, at least 23 days and less than 30 days from the later of:
  - The original date the prescription was distributed to you.
  - The date of the most recent refill was distributed to you.
- For a 60-day supply, at least 45 days and less than 60 days from the later of:
  - The original date the prescription was distributed to you.
  - The date of the most recent refill was distributed to you.
- For a 90-day supply, at least 68 days and less than 90 days from the later of:
  - The original date the prescription was distributed to you.
  - The date of the most recent refill was distributed to you.
- The eye drops to treat glaucoma or ocular hypertension prescribed by the provider are a Covered Health Care Service under the Policy.
- The prescribing provider indicates on the original prescription that additional quantities of the eye drops are needed.
- The refill requested by you does not exceed the number of additional quantities prescribed.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

Please see *Defined Terms for Outpatient Prescription Drugs* for a full description of Specialty Prescription Drug Products.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drug Products 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.

Depending upon your plan design, this section may offer limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com/exchange.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com/exchange 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.

SAMPLE

PPACA and Preventive Care Medications

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), certain preventive medications are available to you at no cost, both prescription and over-the-counter (OTC). These are called PPACA Zero Cost Share Preventive Care Medications. These preventive medications are covered at no cost to you, without charging a Co-payment, Co-insurance, or deductible when:

- Prescribed by a Physician;
- Your age and/or condition is appropriate for the recommended preventive medication;
- The medication is filled at a Network Pharmacy.

Contact us at www.myuhc.com/exchange or call the number on your ID card to find out if a medication is a PPACA Zero Cost Share Preventive Care Medication.

If your health care provider determines you need a medication that is not on the PPACA Zero Cost Share Preventive Care Medication list, they can let us know your medication is Medically Necessary and provide information about your diagnosis and medication history. If you are using your medication for an appropriate condition and it is approved, it will be covered at no cost to you. If you are using it to treat another medical condition, a cost share may apply.

List of Zero Cost Share Medications

You may obtain up to a one-month supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy. Refer to your *Schedule of Benefits* for day supply limits.

You are not responsible for paying any applicable Co-payment, Co-insurance, or deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

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Outpatient Prescription Drugs Exclusions

Exclusions from coverage listed in the Policy *also* apply to this section. 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/exchange or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational services and medications; medications used for experimental or investigational treatments for specific diseases and/or dosage regimens determined by us to be experimental or investigational. The exclusion will not limit or exclude coverage for any prescription drug approved by the *U.S. Food and Drug Administration (FDA)* prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the *United States Food and Drug Administration* for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia.
    - The acceptable standard medical reference compendia are the following:

      The American Hospital Formulary Service Drug Information, a publication of the *American Society of Health System Pharmacists*.

      The National Comprehensive Cancer Network Drugs and Biologics Compendium.

      Thomson Micromedex Compendium DRUGDEX.

      Elsevier Gold Standard's Clinical Pharmacology Compendium.

      Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
    - Medical literature may be accepted if all of the following apply:

      At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

      No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

      The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the *Social Security Act* (42 United States Code section 1395x(t)(2)(B).
7. Unproven Services and medications; medications used for unproven treatments for specific diseases and/or dosage regimens determined by us to be unproven.
8. 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.
9. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
10. Any product dispensed for the purpose of appetite suppression or weight loss.

SAMPLE

11. A Pharmaceutical Product for which Benefits are provided in your Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to certain injectable drugs used for contraception.
12. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered. You may access a complete list of diabetic self-management supplies by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.
13. General vitamins that require a Prescription Order or refill, except for vitamins with fluoride to prevent dental cavities in children.
14. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as a unit dose(s).
15. Prescription Drug Products used for cosmetic purposes.
16. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Care Service.
17. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
18. Prescription Drug Products when prescribed to treat infertility.
19. Prescription Drug Products not placed on a tier of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
20. 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 4.)
21. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
22. Certain New Prescription Drug Products until the date they are reviewed and placed on a tier by our PDL MC and applicable clinical criteria are approved.
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Dental products, including but not limited to prescription fluoride topicals.
28. A Prescription Drug Product with either:

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- 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) and
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
- Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

29. Diagnostic kits and products, including associated services.
30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, including Digital Therapeutics. This exclusion does not apply to Digital Therapeutics for which Benefits are provided as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.*
31. 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.
32. Drugs to treat sexual dysfunction and/or impotency.

SAMPLE

Defined Terms for Outpatient Prescription Drugs

Annual Drug Deductible - the amount you must pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products. The Outpatient Prescription Drug Schedule of Benefits will tell you how the Annual Drug Deductible applies.

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 may include Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Digital Therapeutics - *U.S. Food and Drug Administration (FDA)* approved or cleared therapeutic interventions driven by software or digital technology to prevent, diagnose, monitor, or treat a Sickness, Injury, or Mental Illness.

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

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List (PDL) that are available at zero cost share (no cost to you). You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com/exchange 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.

A Network Pharmacy may be a:

- Retail Network Pharmacy.
- Specialty Network Pharmacy.
- Mail Order Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product, new dosage form, or new indication of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product, new dosage form, or new indication is commercially available following approval 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 MC.
- December 31st of the following calendar year.

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 or 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*.

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/exchange or the telephone number on your ID card.

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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 (PDL) - 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/exchange or the telephone number on your ID card.

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

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Prenatal vitamins.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips;
    - certain insulin pumps;
    - certain continuous glucose monitors;
    - lancets and lancet devices; and
    - glucose meters.

You may access a complete list of diabetic self-management supplies by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical 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 or pricing agreed to by the pharmacy and any third party. This fee includes any applicable dispensing fee and sales tax.

SAMPLE

Section 10: Pediatric Dental Care Services

How Do You Use This Document?

This section provides Benefits for Covered Dental Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Covered Dental Care Services?

You are eligible for Benefits for Covered Dental Care Services listed in this section if such Dental Care Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Care Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this section.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Care Services are provided. It is your Dental Provider's responsibility for obtaining a pre-authorization. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

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Benefits for Pediatric Dental Care Services

Benefits are provided for the Dental Care Services stated in this section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be given a Benefit based on the least costly procedure.

D. Not excluded as described under *Pediatric Dental Exclusions*.

Benefits

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

Pediatric Dental Exclusions

Except as may be specifically provided in this section under the heading *Benefits for Pediatric Dental Care Services*, Benefits are not provided under this section for the following:

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service section under the heading *Benefits for Pediatric Dental Care Services*.
3. Dental Care Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or unproven services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. 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.
10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (*TMJ)*, either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours' notice, telephone consultations and sales tax.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section to the Policy.

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17. Dental Care Services otherwise covered under the Policy but provided after the date individual coverage under the Policy ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Policy ends.
18. Foreign Services are not covered outside of the United States.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
20. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
24. Services that exceed the frequency limitations as identified in this section.

Defined Terms for Pediatric Dental Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Care Services with that provider.

Covered Dental Care Service - a Dental Care Service or Dental Procedure for which Benefits are provided under this section.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Care Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Care Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Care Services and supplies under this section which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
- Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
- Safe with promising efficacy
    - For treating a life-threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as

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defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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Section 11: Pediatric Vision Care Services

How Do You Use This Document?

This section provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

Benefits for Pediatric Vision Care Services

What Are the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Exam

A routine vision exam of the eyes, including refraction, and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

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Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improve binocular function, including avoidance of diplopia or suppression.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Low vision aids, if prescribed, such as spectacles, magnifiers, and telescopes.

Pediatric Vision Exclusions

Except as may be specifically provided in this section under the heading *Benefits for Pediatric Vision Care Services*, Benefits are not provided under this section for the following:

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1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-Spectera Eyecare Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in this section under the heading *Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Orthoptics or vision therapy training and any associated supplemental testing.
9. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
10. Contact lenses if an eyeglass frame and eyeglass lenses are received in the same calendar year.
11. Eyeglass frame and eyeglass lenses if contact lenses are received in the same calendar year.
12. Services or treatments that are already excluded in *Section 2: Exclusions* and Limitations of the Policy.

Claims for Low Vision Care Services

When obtaining low Vision Care Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this section, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Care Services

To file a claim for reimbursement for low Vision Care Services, you must provide all of the following information:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Covered Contact Lens Formulary - a selection of available contact lenses that may be obtained from a Spectera Eyecare Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Spectera Eyecare Network - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this section under the heading *Benefits for Pediatric Vision Care Services.*

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Section 12: Consolidated Appropriations Act Summary

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

No Surprises Act

Balance Billing

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

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

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

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

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

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

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

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes if you:

- Are undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Are undergoing a course of institutional or inpatient care from the provider or facility;
- Are scheduled to undergo a non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility;
- Have entered the third trimester of pregnancy on the effective date of the enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery; or Are determined to be terminally ill and are receiving treatment for such illness from such provider or facility.

A "serious and complex condition" is:

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- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

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

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AZ Health Care Insurer Appeals Process Information Packet

UNITEDHEALTHCARE OF ARIZONA, INC.

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS THAT WE MAKE ABOUT YOUR HEALTH CARE.

IMPORTANT: THE STANDARD APPEAL PROCESS FOR ALL PLANS MUST INCLUDE AN INITIAL APPEAL LEVEL OF REVIEW. FOR SOME PLANS WE MAY ELECT TO OFFER A SECOND INTERNAL LEVEL OF REVIEW CALLED A VOLUNTARY INTERNAL APPEAL. THE VOLUNTARY INTERNAL APPEAL, AND ANY REFERENCE TO THE VOLUNTARY INTERNAL APPEAL IN THIS PACKET, **DOES NOT** APPLY TO YOUR PLAN.

We must send you a copy of this information packet when you first receive your policy, at the request of you or your treating provider, and provide access to a copy of this health care appeals information packet on our www.myuhc.com. When your insurance coverage is renewed, we will send you a reminder that you can request another copy of this packet. Just call our Customer/Member Services number on the CONTACT US page in this packet to request an additional copy.

WHICH DISPUTES ARE ELIGIBLE FOR ARIZONA'S HEALTH CARE APPEALS PROCESS?

You can file an appeal when you are notified by us of an Adverse Determination, which means that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part, is:

- Not medically necessary or appropriate, including the health care setting, level of care or effectiveness of a treatment or service.
- Experimental or investigational.
- Not a covered service.

An Adverse Determination also includes a cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, known as a rescission of coverage.

Examples of disputes that are not eligible for Arizona's Health Care Appeals process include:

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- You disagree with our determination as to the amount we paid for a service or treatment.
- You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
- You disagree with the amount of your cost-share (co-payments and co-insurance) or how we have applied your claims or services to your plan deductible.

If you disagree with a decision we made that is not appealable, contact us at the number on the CONTACT US page in this packet.

WHO CAN FILE A HEALTH CARE APPEAL OR REPRESENT A MEMBER?

You or your treating provider on your behalf can file an appeal. The following authorized representatives can also file an appeal on your behalf:

- A parent or legal guardian.
- A surrogate who is authorized to make health care decisions for the member through a power of attorney, a court order or the provisions of A.R.S. § 36-3231.
- An agent who is an adult and who has the authority to make health care treatment decisions for the member pursuant to a health care power of attorney.

If you are the member and want to file a health care appeal, you can work with your treating provider to help you with information you need to support your appeal. In Arizona, the majority of health care appeals are filed by treating providers.

TOOLS FOR FILING A HEALTH CARE APPEAL

In this packet you will find forms you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("AZ DIFI") developed these forms to help consumers file a health care appeal. You are **not** required to use them and we **cannot** reject your appeal if you do not use them. To file an appeal, you can call us or send us a request in writing. If you need help in filing an appeal, or you have questions about the appeals process, contact us at the phone number on your ID card or listed on the CONTACT US page in this packet.

If you have general questions about health care appeals, you can contact the AZ DIFI's Consumer Services Section at (602) 364-3100 or visit the AZ DIFI website at www.difi.az.gov.

DESCRIPTION OF THE APPEALS PROCESS

There are two types of appeal time frames: an expedited appeal for urgent matters and a standard appeal. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because

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of the patient's condition.

Appeals are categorized as either Medical Necessity or Coverage. The designation will affect how the case is handled by us and by the AZ DIFI, as well as the rights you have once the health care appeals process has been completed.

STANDARD VS EXPEDITED TIME FRAMES: IS IT URGENT?

Generally, a standard appeal for a service not yet provided will be completed within 30 days.

If your appeal is urgent, your treating physician must certify and provide supporting documentation to us that the time frame for a standard appeal review would cause a significant negative change in your condition. There is a provider certification form at the end of this packet, but it is **not** required to be used. Your provider could also send a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

Adverse Determinations Eligible for Expedited Appeal Process

The following is a non-exhaustive list of Adverse Determinations that may be expedited with certification from your provider:

- A denial of a health care service as experimental or investigational.
- A denial of a health care service for which a member has received emergency services but has not been discharged.
- A denial, reduction, or termination of coverage for an admission.
- Availability of care.
- A continued stay for a course of treatment before the end of the period of time or number of treatments recommended by the treating provider.
- A prior authorization denial.

If you already received the service, or it is an issue of policy rescission, it **cannot** be expedited.

GENERAL APPEALS PROCESS INFORMATION

- Your plan may or may not offer a second internal level of review called the Voluntary Internal Appeal. The first page of this packet indicates whether the Voluntary Internal Appeal applies to your plan.

- You have two years from the date of an Adverse Determination to begin the health care appeals process.

- Requests for all health care appeal levels are to be sent directly to us using the information on the CONTACT US page in this packet.

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- An appeal must first go through the Initial Appeal level and, if applicable, the Voluntary Internal Appeal level, or the internal level(s) of review must be waived or deemed exhausted, before seeking an External Independent Review, except that you can simultaneously initiate an Expedited External Independent Review at any internal level of review.

- The Initial Appeal and Voluntary Internal Appeal, if applicable, and the Expedited Medical Review and Expedited Appeal levels of review are completed by us. For the External Independent Review and Expedited External Independent Review levels, we send the appeal to the AZ DIFI.

- At any time we may waive the internal levels of review and move an appeal to the External Independent Review level.

- There is no minimum dollar amount for the value of a claim or service for it to be eligible for the health care appeals process.

- There is no fee to you or your provider for any level of appeal.

- It is important to pay attention to deadlines at each level of review.

- For individual plans, and for group plans that do not elect to offer a Voluntary Internal Appeal level, there are two standard appeal levels:
  1. Initial Appeal.
  2. External Independent Review.

- For group and grandfathered individual plans that elect to offer a Voluntary Internal Appeal level, there are three standard appeal levels:
  1. Initial Appeal.
  2. Voluntary Internal Appeal.
  3. External Independent Review.

- For all plans, there are three expedited appeal levels:
  1. Expedited Medical Review.
  2. Expedited Appeal.
  3. Expedited External Independent Review.

- If the External Independent Review involves medical necessity, the AZ DIFI selects an Independent Review Organization ("IRO") that is completely independent of us to make the determination. The IRO reviewer will be a provider that typically manages the condition that is the subject of the appeal.

- If the appeal involves whether a treatment or service is covered in your policy, the AZ DIFI is the external reviewer.

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EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review

You may obtain Expedited Medical Review of an Adverse Determination for a service that has not already been provided if your treating provider certifies in writing and provides supporting documentation that the time for a standard appeal is likely to cause a significant negative change in your medical condition. At the end of this packet is a form that your treating provider may use, but that form is **not** required. Your provider could also provide a written request or create a form with similar information. Your treating provider must send the certification and documentation to us using the information on the CONTACT US page in this packet.

We have 72 hours after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Medical Review and Expedited Appeal levels and send your appeal to the AZ DIFI for Expedited External Independent Review.

Expedited Appeal

If we deny your Expedited Medical Review, you may request an Expedited Appeal. After you receive our Expedited Medical Review determination, your treating provider must immediately send us a written appeal request using the information in the CONTACT US page in this packet. To help your appeal, your provider should also send us any additional information that the provider has not already sent to show why you need the requested service.

We have three business days after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we must call and tell you and your treating provider about our determination. We must also send you a written determination.

If we overturn our determination, we will authorize the service and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Appeal level and send your appeal to the AZ DIFI for Expedited External Independent Review.

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Expedited External Independent Review

Unless we waive the Expedited Medical Review or Expedited Appeal levels of review and send your appeal to the AZ DIFI for Expedited External Independent Review, you may request an Expedited External Independent Review after you have completed an Expedited Medical Review and an Expedited Appeal or simultaneously at any internal level of review. You have four months after you receive a Final Internal Adverse Determination to send to us your written request for Expedited External Independent Review. If the treatment or service is considered experimental or investigational, you can make an oral request if your treating physician certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated. Send us your request and any additional supporting information using the information in the CONTACT US page in this packet.

There are two types of Expedited External Independent Review depending on the issue in your case: Medical Necessity or Contract Coverage.

(A) Medical Necessity

These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:

  1. Send a written acknowledgement of the appeal request to the AZ DIFI, you, and your treating provider.

  2. Send the AZ DIFI all of the following:
     a. The request for review.
     b. Your policy, evidence of coverage or similar document.
     c. All medical records and supporting documentation used to render our determination.
     d. A summary of the applicable issues, including a statement of our determination.
     e. The criteria used and clinical reasons for our determination.
     f. The relevant portions of our utilization review guidelines.
     g. The name and credentials of the health care provider who reviewed and upheld the denial at the internal levels of review.

- Within two business days of receiving the appeal the AZ DIFI must send all the submitted information to the IRO.

- Within 72 hours of receiving the appeal the IRO must make a determination and send their determination to the AZ DIFI.

- Within one business day of receiving the IRO's determination the AZ DIFI must send a notice of the determination to you, your treating provider, and us.

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The determination*:* If the IRO decides that we should provide the service we must authorize the service. If the IRO agrees with our determination to deny the service the appeal is over and your only further option is to pursue a claim in Superior Court.

(B) Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases the AZ DIFI is the independent reviewer. Contract Coverage appeals are subject to the following time frames:

- Within one business day of receiving your request, we must:

    1. Send a written acknowledgement of the request to the AZ DIFI, you, and your treating provider.

    2. Send the AZ DIFI all of the following:
        a. The request for review.
        b. Your policy, evidence of coverage or similar document.
        c. All medical records and supporting documentation used to render our determination.
        d. A summary of the applicable issues, including a statement of our determination.
        e. The criteria used and any clinical reasons for our determination.
        f. The relevant portions of our utilization review guidelines.

- Within two business days of receiving this information the AZ DIFI must determine whether the service or claim is covered under your insurance policy and send a written notice of their determination to you, your treating provider, and us.

Referral to an IRO for Contract Coverage Appeals*:* The AZ DIFI may be unable to determine issues of coverage. If this occurs, the AZ DIFI will forward the case to an IRO. The IRO will have 72 hours to make a determination and send it to the AZ DIFI. The AZ DIFI will have one business day after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The determination: If the AZ DIFI decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the Arizona Office of Administrative Hearings ("AZ OAH") by sending a request to the AZ DIFI within 30 days after receiving the AZ DIFI's determination.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Initial Appeal

You can request an Initial Appeal of an Adverse Determination if all of the following apply:

- You have coverage with us.

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- We denied your request for a covered service or claim.
- You request an appeal within two years after the date we make the Adverse Determination.
- You do not qualify to have your appeal expedited.
- You send your request to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive internal review and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy of the new information along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- For individual plans, and for group plans or grandfathered individual plans that do not elect to offer a voluntary internal appeal level, we have:
  a. 30 days to make a determination for a service not yet provided.
  b. 60 days to make a determination for a service already provided.

- For group plans and for grandfathered individual plans that elect to offer a Voluntary Internal appeal level, we have:
  a. 15 days to make a determination for a service not yet provided.
  b. 30 days to make a determination for a service already provided.

We must send you and your treating provider a written determination letter within the time frames above.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.

If we deny your appeal, our determination letter will explain the reasons for our determination and the information on which we based our determination. Our determination letter will also include instructions for the next steps in the appeal process, subject to the following time frames:

- For individual plans, and for group plans that do not elect to offer a voluntary internal appeal level, you have 4 months to request an External Independent Review.

- For group plans and for grandfathered individual plans that elect to offer a voluntary internal appeal level, you have 60 days to request a Voluntary Internal Appeal.

Voluntary Internal Appeal

This level of appeal applies only if you have a group plan or grandfathered individual plan, we elect to offer this level of appeal, and you previously completed an Initial Appeal.

You or your treating provider must send to us a written request within 60 days of an Initial Appeal determination to tell us you want a Voluntary Internal Appeal. To help us make a determination on your appeal, you or your provider should also send us any additional information that you have not already sent to show why we should authorize the requested service or pay the claim. Send your appeal request and

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information to us using the information in the CONTACT US page in this packet.

At any time we may decide to waive the Voluntary Internal Appeal level and send your appeal to the AZ DIFI for External Independent Review.

Before we make a Final Internal Adverse Determination that relies on new or additional information generated by us, we must provide you with a copy along with a reasonable opportunity to respond within the applicable time frames for us to provide a written determination.

Determination and Time Frames:

- We have 15 days to make a determination for a service not yet provided.
- We have 30 days to make a determination for a service already provided.

If we overturn our determination, we will authorize the service or pay the claim and the appeal is over.

If we deny your appeal, our determination will explain the reasons for our determination and the information on which we based our determination. Our determination will also include instructions for the next steps in the appeal process. You have four months to appeal to the External Independent Review level.

External Independent Review

You may appeal to the External Independent Review level only after you have completed the internal level(s) of appeal. You have four months after you receive a Final Internal Adverse Determination to send us your written appeal request and any additional supporting information for External Independent Review. Send your request to us using the information in the CONTACT US page in this packet.

This level of review also applies if we elect to waive the internal level(s) of review.
There are two types of External Independent Review, depending on the issues in your case: Medical Necessity or Contract Coverage.

(A) Medical Necessity

These are cases where we have decided not to authorize a service because we determined that the service you or your treating provider are asking for is not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, which is procured by the AZ DIFI and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review. Medical necessity appeals are subject to the following time frames:

- Within five business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the AZ DIFI, you, and your treating provider. This acknowledgment must include notice that you have five business days after receiving the notice to submit any additional written evidence to the AZ DIFI for consideration by the external reviewer. The AZ DIFI will forward it to the IRO. If you provide additional information after five business days the IRO may or may not consider

SAMPLE

it.

2. Send the AZ DIFI all of the following:
    a. The request for review.
    b. Your policy, evidence of coverage or similar document.
    c. All medical records and supporting documentation used to render our determination(s).
    d. A summary of the applicable issues including a statement of our determination.
    e. The criteria used and clinical reasons for our determination.
    f. The relevant portions of our utilization review guidelines.
    g. The name and credentials of the health care provider who reviewed and upheld the determination(s) at the initial appeal and, if applicable, the voluntary internal appeal level.

- Within five days of receiving the appeal the AZ DIFI must send all the submitted information to an IRO.

- Within 21 days of receiving the appeal the IRO must make a written determination and send the determination to the AZ DIFI.

- Within five business days of receiving the IRO's determination the AZ DIFI must send a written notice of the determination to you, your treating provider, and us.

The determination: If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our determination to deny the service or payment, the appeal is over and your only further option is to pursue a claim in Superior Court.

(B) Contract Coverage

These are cases where we have denied coverage because we determined that the requested service is not covered under your insurance policy. For contract coverage cases, the AZ DIFI is the independent reviewer. Contract coverage appeals are subject to the following time frames:

- Within five business days of receiving your request, we must:

1. Send a written acknowledgement of your request to the AZ DIFI, you, and your treating provider.

2. Send the AZ DIFI all of the following:
    a. The request for review.
    b. Your policy, evidence of coverage or similar document.
    c. All medical records and supporting documentation used to render our determination(s).
    d. A summary of the applicable issues including a statement of our determination.
    e. The criteria used and clinical reasons for our determination.
    f. The relevant portions of our utilization review guidelines.
    g. The name and credentials of the health care provider who reviewed and upheld the determination(s) at the initial appeal and, if applicable, the voluntary internal appeal level.

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- Within 15 business days of receiving this information the AZ DIFI must determine whether the service or claim is covered and send a written notice of their determination to you, your treating provider, and us.

Referral to an IRO for Contract Coverage Appeals: The AZ DIFI may be unable to determine issues of coverage. If this occurs, the AZ DIFI will forward the case to an IRO. The IRO will have 21 days to make a determination and send it to the AZ DIFI. The AZ DIFI will have five business days after receiving the IRO's determination to send the notice of determination to you, your treating provider, and us.

The determination: If the AZ DIFI decides that we should provide the service or pay the claim, we must do so. If either you or we disagree with the AZ DIFI's determination on a coverage issue, you or we may request a hearing with the AZ OAH by sending a request to the AZ DIFI within 30 days after receiving the AZ DIFI's determination..

NOTES ON INDEPENDENT REVIEW ORGANIZATIONS (IROs)

- The AZ DIFI contracts directly with multiple IROs. They each maintain large rosters of many types of specialties of physicians and other licensed health care professionals.

- There is no cost to a member or provider for any part of the appeal process. If the services of an IRO are used, the AZ DIFI selects and pays the IRO, then bills the insurer for reimbursement after the appeal is completed.

- The IRO will check that their reviewer does not have a conflict of interest with the insurer, member, or treating provider, and was not involved in the original denial determination or any previous appeal for the same member.

- There will be no communication with the IRO by you or us. The IRO will complete their review using the documentation in your appeal.

- The IRO reviewer will be a provider who typically manages the condition under review.

- The IRO's determination is binding on all parties. Any further challenges must proceed through Superior Court.

- Even if determined to be medically necessary, neither the IRO, the AZ DIFI, or the AZ OAH can order an insurer to provide or pay for a treatment or service that is excluded in a policy.

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OBTAINING MEDICAL RECORDS

Arizona law (A.R.S. § 12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. § 12-2293 remain confidential. If you participate in the appeal process the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

DOCUMENTATION FOR AN APPEAL

If you file an appeal, you must include any material justification or documentation. If you gather new information during the course of your appeal you should give it to us as soon as you get it. You must also give us the address and phone number or email where you can be contacted.

If your appeal goes to external review, the AZ DIFI may contact you by email from a generic email address (hca@difi.az.gov). If the appeal is already at the External Independent Review level, you will be notified in writing that you have five business days to send any additional information to the AZ DIFI. If you submit anything after the five business days, it does not have to be considered in your appeal.

THE ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS (AZ DIFI)

Arizona law requires "any member who files a complaint with the [AZ DIFI] relating to an Adverse Determination to pursue the review process prescribed" by law (A.R.S. § 20-2533(F)). This means that you must pursue the health care appeals process for all appealable adverse determinations before the AZ DIFI can investigate a complaint you may have against our company based on the determination at issue in the appeal.

The appeal process requires the AZ DIFI to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External Independent Review.
4. Enforce the determinations of insurers.
5. Review determinations of insurers.

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6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the AZ OAH.
7. Issue a final administrative determination on coverage issues, including the notice of the right to request a hearing at AZ OAH.

RECEIPT OF DOCUMENTS

Any written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. "Properly addressed" means your last known mailing address. Any document may alternatively be sent electronically where a member has elected electronic delivery.

SAMPLE

CONTACT US

UNITEDHEALTHCARE OF ARIZONA, INC.

UnitedHealthcare of Arizona, Inc.
Phone: (877) 482-9045

Website: www.myuhc.com

SEND YOUR HEALTH CARE APPEAL TO:

For Pharmacy Appeals:
Optum Rx Prior Authorization Appeals c/o Appeals Coordinator
PO Box 2975
Mission, KS 66201
Phone: (888) 403-3398
Fax: (877) 239-4565

For All Other Appeals
UnitedHealthcare Appeals & Complaints
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630
Phone: (877) 482-9045
Fax: (888) 808-9123 (urgent)
Fax: (888) 404-0949 (standard)

SAMPLE

Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

UnitedHealthcare complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: **UHC_Civil_Rights@uhc.com**

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at: **https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

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Language Assistance Services 1-877-265-9199, TTY 711

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ ኣትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታውቂያ ቁጥርዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا كنت تتحدث اللغة **العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة .اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ।

আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

ATENSION: Yanggen fifino' hao **Chamoru (Chamorro)** guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang i dibåtdi na numiru gi kattå-mu aidentifikasion membro.

請注意：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

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ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole),** gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

PANANGIKASO: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

ATTENZIONE: Se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

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や、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。[] にお電話ください。

알림사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáá łahgo át'éego bee hadadilyaa bee ahił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

GEB ACHT: Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht, Schprooch Helfe mitaus Koscht un Communications in annere Formats wie groosse Druck iss meeglich. Ruf die koschdelos Nummer uff dei Member Identification Kaart.

PAKAIR: Mah ke ese lokaian **Pohnpei (Pohnpeian)**, sahpis en sawas en lokaia oh mehn kapehse ni soangen mwohmw teikan kin sohte isepe, me duwehte inting lapala, kak kohda ohng kowe. Eker nempe ni sohte isepe me mih pohn noumw doaropwehn tohn pwihn ID.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

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ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FA‘AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan),** o lo‘o avanoa mo oe ‘au‘aunaga fesoasoani tau gagana e leai se totogi ma feso‘ota‘iga e leai se totogi i isi faiga, e pei o lomiga e lapopo‘a mata‘itusi. Valaau i le numera e leai se totogi i lau kata faailo o le sui auai (ID).

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

PAUNAWA: Kung nagsasalita ka **ng Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

శ్రద్ధ: మీరు **తెలుగు (Telugu)** మాట్లాడేవారైతే, మీకు ఉచిత భాషా సహాయ సేవలు మరియు పెద్ద ముద్రణ వంటి ఇతర ఫార్మాట్‌లలో కమ్యూనికేషన్‌లు ఉచితంగా లభిస్తాయి. మీ మెంబరు ఐడింటిఫికేషన్ కార్డులోని టోల్-ఫ్రీ నెంబరుకి కాల్ చేయండి.

โปรดทราบ หากคุณพูดไทย **(Thai)** ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

УВАГА: Якщо ви розмовляєте **українською (Ukrainian)**, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом. Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.

توجہ دیں: (Urdu) اگر آپ **اردو** زبان بولتے ہیں تو آپ کے لیے زبان کی معاون خدمات اور دیگر فارمیٹ میں مفت مواصلات، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

LƯU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.

SAMPLE