UnitedHealthcare of Illinois, Inc.

Individual Exchange Medical Policy

200 West Madison, Suite 2600

Chicago, IL 60606

888-200-0325

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [January 1, 2027]

Total Premium - [$100.00]

Premium Mode - [Monthly] [Quarterly]

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

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UnitedHealthcare of Illinois, 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 31 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 Illinois, Inc.



Thomas C. Kunst, President and CEO

SAMPLE

UnitedHealthcare Individual Exchange Policy

UnitedHealthcare of Illinois, Inc.

Schedule of Benefits

Covered Health Care Services Schedule of Benefits

UHC Bronze Value Open (Virtual Urgent Care, Rx Copay, HSA, No Referrals)

IL0046, $7,850

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 promote continuity of care.

You can get a list of Network Primary Care Physicians 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.

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.*

SAMPLE

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.

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. The Annual Deductible 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 Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Pediatric Dental Care Services* section and the *Pediatric Vision Care Services* section. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a	$7,850 per Covered Person, not to exceed $15,700 for all Covered Persons in a family.

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Payment Term And Description	Amounts
result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible or Co-payments. 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 Person, not to exceed $24,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

SAMPLE

Schedule of Benefits Table

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 You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Abortion Care Services			
	None	Yes	No
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:* 50%	Yes	Yes
	Air Ambulance: 50%	Yes	Yes
Urgent Ambulance Allowed Amounts for ground transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance:* 50%	Yes	Yes
	Air Ambulance: 50%	Yes	Yes
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:* 50%	Yes	Yes
	Air Ambulance: 50%	Yes	Yes
Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	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*.		
Dental Anesthesia			

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	40%	Yes	Yes
Dental Services - Accident Only			
	40%	Yes	Yes
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. • Lab tests to assess Glucose control (HbA1c). 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.		
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.	40%	Yes	Yes
Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after	*Facility Services* 50%	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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 and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Physician Services* 50%	Yes	Yes
Examination and Treatment for Sexual Assault	None	Yes	No
Enteral Nutrition			
Human Breast Milk Treatment for Enrolled Dependents through 12 months of age.	40%	Yes	Yes
Fertility Preservation for Iatrogenic Infertility			
	40%	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Gender Dysphoria			
It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drugs* section.		
Habilitative Services			
Visit limits do not apply.	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 40%	Yes	Yes
Hearing Aids			
Benefits are available to Covered Persons of any age, and are limited to one hearing instrument (hearing aid) per hearing impaired ear every three years, for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary. Bone anchored hearing aids are described under *Surgery - Outpatient*.	40%	Yes	Yes
Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify.	40% *Private Duty Nursing* 40%	Yes Yes	Yes Yes
Hospice Care			

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	40%	Yes	Yes
Hospital - Inpatient Stay			
	40%	Yes	Yes
Infertility Treatment			
Coverage for treatments that include oocyte retrievals will be provided only when you have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered. The maximum number of completed oocyte retrievals that are eligible for coverage under this Policy in your lifetime is six. Following the final completed oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no Benefits for Infertility treatment.	40%	Yes	Yes
Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	$20 per service at a freestanding lab or in a Physician's office	Yes	No
	$150 per service at a Hospital-based lab	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Major Diagnostic and Imaging - Outpatient			
	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
Manipulative Treatment			
Limited per year as follows: • 25 visits of Manipulative treatments. • 15 visits of naprapathic services.	40%	Yes	Yes
Mental Health Care and Substance Use Disorder Services			
Inpatient Mental Health Care Services and Substance Use Disorder Services are not subject to prior authorization requirements.	*Inpatient (includes Residential Treatment)*		
	40%	Yes	Yes
	Outpatient		
	40% for Intensive Outpatient Program	Yes	Yes
	40% for Partial Hospitalization	Yes	Yes
	40% for all other outpatient services including Intensive Behavioral Therapy, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, and Psychological Testing	Yes	Yes
	Office Visit		

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	$40 per visit	Yes	No
Mobile Integrated Health Care Services			
	Depending on the type of Covered Health Care Service provided, Benefits will be the same as those stated under that Covered Health Care Service category in this *Schedule of Benefits*.		
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.	40% at a freestanding surgical center	Yes	Yes
	40% at an outpatient Hospital-based surgical center	Yes	Yes
Necessary Medical Supplies			
	40%	Yes	Yes
Neuromuscular, Neurological, or Cognitive Impairment Treatment			
	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*.		
Orthotics			
	40%	Yes	Yes
Pharmaceutical Products - Outpatient			
Pharmaceutical Products which, due to their traits, are administered or directly supervised by a qualified provider or licensed/certified health professional.	40%	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Note: Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drugs* section.			
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*		
	40%	Yes	Yes
	Outpatient		
	40% at a freestanding center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based center	Yes	Yes
Physician's Office Services - Sickness and Injury			
Co-payment and any deductible for the 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*.	$40 per visit for services provided by your Primary Care Physician	Yes	No
	$150 per visit for services provided by a Network Specialist	Yes	No
	40% for services provided by any other Network Physician	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• 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*.			
Pregnancy - Maternity Services			
Home visits by a perinatal doula are limited to 16 visits before and 16 visits after a birth, miscarriage, or abortion for each pregnancy and postpartum period.	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* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
Breast pumps	None	Yes	No
Prosthetic Devices			
Limited to one wig or hair prosthesis per year.	40%	Yes	Yes
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			
Visit limits do not apply.	40%	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	40%	Yes	Yes
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
	Skilled Nursing Facility		
	40%	Yes	Yes
	Inpatient Rehabilitation Facility		
	40%	Yes	Yes
Surgery - Outpatient			
	40% at a freestanding surgical center	Yes	Yes
	40% at an outpatient Hospital-based surgical center	Yes	Yes
Telehealth Services			
	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)			
	40%	Yes	Yes
Therapeutic Treatments - Outpatient			
	Chemotherapy 40%	Yes	Yes
	Dialysis 40%	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Infusion Therapy 40%	Yes	Yes
	Radiation 40%	Yes	Yes
	All Other Treatments 40%	Yes	Yes
PANDAS/PANS and Tick-Borne Disease	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*.		
Transplantation Services			
Transplantation services must be received from a Designated Provider.	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 required to treat your condition in an Urgent Care setting. Benefits are available for out-of-Network Urgent Care Center services.	*Network* $60 per visit	Yes	No
	Out-of-Network $60 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

SAMPLE

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 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 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 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 applicable Co-payment 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-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

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amounts in excess of your applicable Co-payment 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 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)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment 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 or urgent 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. You are only responsible for the allowable charges (Co-payment and/or deductible) which will not be greater than the out-of-pocket costs that would have been incurred with a participating ground ambulance provider.

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.

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- When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

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

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com/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 and applicable deductible) that would be no greater than if the service had been provided from a Network provider. This also applies to Network providers who refuse to provide a Covered Health Care Service because it is contrary to the conscience of the Network provider, as protected by the *Health Care Right of Conscience Act*.

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.

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.

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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. You will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or provider for Allowed Amounts.

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

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

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

If you do 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 you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. 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 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 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 Service.

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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 based on the Prescription Drug Product tier placement, or at the highest tier.

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 drug 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 health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

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

Expedited External Review

If you are not satisfied with our determination of your 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 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 Deductible.

You are responsible for paying the applicable Co-payment described in the *Benefit Information* table. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.

The Co-payment amount 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

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
Co-payment	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount or a percentage of the Prescription Drug Charge. **Special Programs**: We may have certain programs in which you may receive a reduced Co-payment 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. • 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. • The Prescription Drug Charge for that Prescription Drug Product. You are not responsible for paying a Co-payment 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 at $0 cost to you. The Co-payment you pay for a covered prescription insulin drug will not exceed $35 for a 30-day supply. The Co-payment you pay for epinephrine delivery systems will not exceed $60 per twin-pack of epinephrine delivery systems regardless of the type of epinephrine delivery system. The Co-payment you pay for a prescription inhaler will not exceed $25 for a 30-day supply, and no deductible will apply.

Schedule of Benefits Information Table

- Your Co-payment 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 a 30-day supply with three refills.
- You will be charged a Co-payment based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.
- You may receive up to a 12-month cycle of the same contraceptive for subsequent dispensing at one time if you pay a Co-payment for each cycle supplied, when the prescriber writes the prescription to fill a 12-month

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supply. If the contraceptive medication prescribed is listed as a PPACA Zero Cost Share Preventive Care Medication the Co-payment will be $0.

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 Deductible.	None Not subject to payment of the Annual Deductible.	None Not subject to payment of the Annual Deductible.
Tier 2	$10 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$25 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$25 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 3	$200 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$500 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$500 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 4	$400 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$1,000 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$1,000 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 5	$500 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$1,250 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$1,250 per Prescription Order or Refill. Not subject to payment of the Annual 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 Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental 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. 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.

Annual Deductible

Unless otherwise stated in the below *Schedule of Benefits*, Benefits for Pediatric Dental Care Services provided under this section are subject to the Annual Deductible stated in the medical *Schedule of Benefits*.

Out-of-Pocket Limit - any amount you pay in Co-payment 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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)	
Evaluations (Checkup Exams) Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. Periodic oral evaluation. Limited oral evaluation - problem focused.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Teledentistry - synchronous - real time encounter. Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. Comprehensive oral evaluation- new or established patient. Comprehensive periodontal evaluation- new or established patient. Detailed and extensive oral evaluation - problem focused, by report.	
Intraoral Radiographs (X-ray) Limited to 1 series of films per 36 months. Intraoral - comprehensive series of radiographic images. Intraoral - comprehensive series of radiographic images - image capture only. Intraoral tomosynthesis - comprehensive series of radiographic images. Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only.	None
The following services are limited to 2 per 12 months. Intraoral - periapical first radiographic image. Intraoral - periapical - each additional radiographic image. Intraoral - occlusal radiographic image. Intraoral tomosynthesis - periapical radiographic image. Intraoral tomosynthesis - periapical radiographic image - image capture only. Intraoral - occlusal radiographic image - image capture only. Intraoral - periapical radiographic image - image capture only.	None
Any combination of the following services is limited to 2 series of films per calendar year. Bitewing - single radiographic image. Bitewings - two radiographic images. Bitewings - four radiographic images.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Vertical bitewings - 7 to 8 radiographic images. Intraoral tomosynthesis - comprehensive series of radiographic images. Intraoral tomosynthesis - bitewing radiographic image - image capture only. Intraoral - bitewing radiographic image - image capture only.	
Limited to 1 time per 36 months. Panoramic radiograph image. Panoramic radiographic image - image capture only. 2-D Cephalometric radiographic image - image capture only.	None
The following service is limited to two images per calendar year. Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. 2-D Cephalometric radiographic image - acquisition, measurement, and analysis. 2-D Oral/facial photographic images obtained intra-orally or extra-orally. Diagnostic casts. 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) *The following services are limited to 1 time every 6 months*.	None
Fluoride Treatments *The following services are limited to 1 time every 6 months.*	None
Sealants (Protective Coating) *The following services are limited to 1 per lifetime per tooth*. Sealant - per tooth. Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Space Maintainers (Spacers) *The following services are limited to to 1 per lifetime.* Space maintainer - fixed, unilateral - per quadrant. Space maintainer - fixed - bilateral maxillary. Space maintainer - fixed - bilateral mandibular. Space maintainer - removable, unilateral - per quadrant. Space maintainer - removable - bilateral maxillary. Space maintainer - removable - bilateral mandibular. Re-cement or re-bond bilateral space maintainer - maxillary. Re-cement or re-bond bilateral space maintainer - mandibular. Re-cement or re-bond unilateral space maintainer - per quadrant. Removal of fixed unilateral space maintainer - per quadrant. Removal of fixed bilateral space maintainer - maxillary. Removal of fixed bilateral space maintainer - mandibular. Distal shoe space maintainer - fixed - unilateral - per quadrant.	None
Minor Restorative Services - (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) *The following services are limited to 1 filling per 12 months per tooth.* Amalgams - one surface, primary or permanent. Amalgams - two surfaces, primary or permanent. Amalgams - three surfaces, primary or permanent. Amalgams - four or more surfaces, primary or permanent.	40%
Composite Resin Restorations (Tooth Colored Fillings)	40%

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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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
The following services are limited to 1 filling per 12 months per tooth. Resin-based composite - one surface, anterior. Resin-based composite - two surfaces, anterior. Resin-based composite - three surfaces, anterior. Resin-based composite - four or more surfaces(anterior). Excavation of a tooth resulting in the determination of non-restorability.	
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)	
The following services are subject to a limit of one time every 60 months. Onlay - metallic - two surfaces. Onlay - metallic - three surfaces. Onlay - metallic - four or more surfaces. Crown - porcelain/ceramic. Crown - porcelain fused to high noble metal. Crown - porcelain fused to predominately base metal. Crown - porcelain fused to noble metal. Crown - porcelain fused to titanium and titanium alloys. Crown - 3/4 cast high noble metal. Crown - 3/4 cast predominately base metal. Crown - 3/4 porcelain/ceramic. Crown - full cast high noble metal. Crown - full cast predominately base metal. Crown - full cast noble metal. Crown - titanium and titanium alloys. Prefabricated stainless steel crown - primary tooth. Prefabricated stainless steel crown - permanent tooth. *The following services are not subject to a frequency limit.* Inlay - metallic - one surface. Inlay - metallic - two surfaces.	40%

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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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Inlay - metallic - three surfaces. Re-cement or re-bond inlay. Re-cement or re-bond crown.	
The following service is not subject to a frequency limit. Protective restoration.	40%
The following service is limited to one time per tooth every 60 months. Core buildup, including any pins when required. Pin retention - per tooth, in addition to restoration.	40%
The following service is not subject to a frequency limit. Prefabricated post and core in addition to crown.	40%
The following services are not subject to a frequency limit. Crown repair necessitated by restorative material failure. Inlay repair necessitated by restorative material failure. Onlay repair necessitated by restorative material failure.	40%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Therapeutic pulpotomy (excluding final restoration). Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	40%
The following services are not subject to a frequency limit. Endodontic therapy, anterior tooth (excluding final restoration).	40%

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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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Endodontic therapy, premolar tooth (excluding final restoration). Endodontic therapy, molar tooth (excluding final restoration). Retreatment of previous endodontic therapy - anterior. Retreatment of previous endodontic therapy - premolar. Retreatment of previous endodontic therapy - molar.	
The following services are not subject to a frequency limit. Apexification/recalcification - initial visit. Apexification/recalcification/pulpal regeneration - interim medication replacement. Apexification/recalcification - final visit.	40%
The following services are not subject to a frequency limit. Apicoectomy - anterior. Apicoectomy - premolar (first root). Apicoectomy - molar (first root). Apicoectomy - (each additional root). Root amputation - per root. Surgical repair of root resorption - anterior. Surgical repair of root resorption - premolar. Surgical repair of root resorption - molar. Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	40%
The following services are not subject to a frequency limit. Hemisection (including any root removal), not including root canal therapy. Intraorifice barrier.	40%

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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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 36 months. Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	40%
The following service is limited to one every 36 months. Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant. Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. Clinical crown lengthening - hard tissue.	40%
The following services are limited to one every 36 months. Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded teeth spaces per quadrant. Bone replacement graft - retained natural tooth - first site in quadrant. Removal of non-resorbable barrier.	40%
The following service is not subject to a frequency limit. Pedicle soft tissue graft procedure.	40%
The following services are not subject to a frequency limit. Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft. Non-autogenous connective tissue graft first tooth implant. Free soft tissue graft procedure - first tooth.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Free soft tissue graft procedure - each additional contiguous tooth. Splint - intra-coronal; natural teeth or prosthetic crowns. Splint - extra-coronal; natural teeth or prosthetic crowns.	
The following services are limited to one time per quadrant every 24 months. Periodontal scaling and root planing - four or more teeth per quadrant. Periodontal scaling and root planing - one to three teeth per quadrant. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	40%
The following service is limited to a frequency of one per lifetime. Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit.	40%
The following service is limited to 2 times every 12 months. Periodontal maintenance.	40%
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. Complete denture - maxillary. Complete denture - mandibular. Immediate denture - maxillary. Immediate denture - mandibular. Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth). Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth). Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. 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. Adjust complete denture - maxillary. Adjust complete denture - mandibular. Adjust partial denture - maxillary. Adjust partial denture - mandibular. Repair broken complete denture base. Repair broken complete denture base - mandibular. Repair broken complete denture base - maxillary. Replace missing or broken teeth - complete denture. Repair resin partial denture base - mandibular.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Repair resin partial denture base - maxillary. Repair cast partial framework - mandibular. Repair cast partial framework - maxillary. Repair or replace broken retentive/clasping materials - per tooth. Replace broken teeth - per tooth. Add tooth to existing partial denture. 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. Rebase complete maxillary denture. Rebase complete mandibular denture. Rebase maxillary partial denture. Rebase mandibular partial denture. Rebase hybrid prosthesis. Reline complete maxillary denture (direct). Reline complete mandibular denture (direct). Reline maxillary partial denture (direct). Reline mandibular partial denture (direct). Reline complete maxillary denture (indirect). Reline complete mandibular denture (indirect). Reline maxillary partial denture (indirect). Reline mandibular partial denture (indirect). Add metal substructure to acrylic full denture (per arch).	40%
The following services are not subject to a frequency limit. Tissue conditioning (maxillary). Tissue conditioning (mandibular). Soft liner for complete or partial removable denture - indirect.	40%
Bridges (Fixed partial dentures) - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Pontic - cast high noble metal. Pontic - cast predominately base metal.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Pontic - cast noble metal. Pontic - titanium and titanium alloys. Pontic - porcelain fused to high noble metal. Pontic - porcelain fused to predominately base metal. Pontic - porcelain fused to noble metal. Pontic - porcelain fused to titanium and titanium alloys. Pontic - porcelain/ceramic.	
The following services are not subject to a frequency limit. Retainer - cast metal for resin bonded fixed prosthesis. Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	40%
The following services are limited to one time every 60 months. Retainer crown - porcelain/ceramic. Retainer crown - porcelain fused to high noble metal. Retainer crown - porcelain fused to predominately base metal. Retainer crown - porcelain fused to noble metal. Retainer crown - porcelain fused to titanium and titanium alloys. Retainer crown - 3/4 cast high noble metal. Retainer crown - 3/4 cast predominately base metal. Retainer crown - 3/4 cast noble metal. Retainer crown - 3/4 porcelain/ceramic. Retainer crown - 3/4 titanium and titanium alloys. Retainer crown - full cast high noble metal. Retainer crown - full cast predominately base metal. Retainer crown - full cast noble metal.	40%
The following services are not subject to a frequency limit. Re-cement or re-bond FPD.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
FPD repair necessitated by restorative material failure.	
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Extraction, erupted tooth or exposed root. Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. Removal of impacted tooth - soft tissue. Removal of impacted tooth - partially bony. Removal of impacted tooth - completely bony. Removal of impacted tooth - completely bony with unusual surgical complications. Surgical removal or residual tooth roots. Coronectomy - intentional partial tooth removal, impacted teeth only.	40%
The following service is not subject to a frequency limit. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	40%
The following service is not subject to a frequency limit. Surgical access exposure of an unerupted tooth.	40%
The following services are not subject to a frequency limit. Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces per quadrant. Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
The following service is not subject to a frequency limit. Removal of lateral exostosis (maxilla or mandible).	40%
The following services are not subject to a frequency limit. Marsupialization of odontogenic cyst. Incision and drainage of abscess. Suture of recent small wounds up to 5 cm. Bone replacement graft for ridge preservation - per site. Buccal/labial frenectomy (frenulectomy). Lingual frenectomy (frenulectomy). Excision of pericoronal gingiva.	40%
The following services are limited to one every 36 months. Guided tissue regeneration, edentulous area - resorbable barrier, per site. Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	40%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
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. Palliative treatment of dental pain - per visit.	40%
Covered only when clinically Necessary. Deep sedation/general anesthesia - first 15 minutes. Dental sedation/general anesthesia - each 15 minute increment. Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. Therapeutic parenteral drug single administration.	40%
Covered only when clinically Necessary. Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
The following is limited to one guard every 12 months. Occlusal guard - hard appliance, full arch. Occlusal guard - soft appliance, full arch. Occlusal guard - hard appliance, partial arch.	40%
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. Surgical placement of implant body: Endosteal implant. Surgical placement of interim implant body. Surgical placement of Eposteal implant. Surgical placement: transosteal implant. Connecting bar - implant supported or abutment supported. Prefabricated abutment – includes modification and placement. Custom fabricated abutment – includes placement. Abutment supported porcelain/ceramic crown. Abutment supported porcelain fused to metal crown (high noble metal). Abutment supported porcelain fused to metal crown (predominately base metal). Abutment supported porcelain fused to metal crown (noble metal). Abutment supported cast metal crown (high noble metal). Abutment supported cast metal crown (predominately base metal). Abutment supported cast metal crown (noble metal). Implant supported porcelain/ceramic crown. Implant supported crown - porcelain fused to high noble alloys. Implant supported crown - high noble alloys. Abutment supported retainer for porcelain/ceramic FPD.	40%

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Abutment supported retainer for porcelain fused to metal FPD (high noble metal). Abutment supported retainer for porcelain fused to metal FPD (predominately base metal). Abutment supported retainer for porcelain fused to metal FPD (noble metal). Abutment supported retainer for cast metal FPD (high noble metal). Abutment supported retainer for cast metal FPD (predominately base metal). Abutment supported retainer for cast metal FPD (noble metal). Implant supported retainer for ceramic FPD. Implant supported retainer for FPD - porcelain fused to high noble alloys. Implant supported retainer for metal FPD - high noble alloys. Implant maintenance procedure. 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. Implant supported crown - porcelain fused to predominantly base alloys. Implant supported crown - porcelain fused to noble alloys. Implant supported crown - porcelain fused to titanium and titanium alloys. Implant supported crown - predominantly base alloys. Implant supported crown - noble alloys. Implant supported crown - titanium and titanium alloys. Accessing and retorquing loose implant screw - per screw. Repair implant supported prosthesis, by report. Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment.	

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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Repair implant abutment, by report. Remove broken implant retaining screw. Abutment supported crown - porcelain fused to titanium and titanium alloys. Implant supported retainer - porcelain fused to predominantly base alloys. Implant supported retainer for FPD - porcelain fused to noble alloys. Surgical removal of implant body. Debridement peri-implant defect. Debridement and osseous contouring of a peri-implant defect. Bone graft for repair peri-implant defect. Bone graft at time of implant replacement. Removal of implant body not requiring bone removal nor flap elevation. Implant/abutment supported interim fixed denture for edentulous arch - mandibular. Implant/abutment supported interim fixed denture for edentulous arch - maxillary. Implant supported retainer - porcelain fused to titanium and titanium alloys. Implant supported retainer for metal FPD - predominantly base alloys. Implant supported retainer for metal FPD - noble alloys. Implant supported retainer for metal FPD - titanium and titanium alloys. Radiographic/surgical implant index, by report. Semi-precision abutment - placement. Semi-precision attachment - placement. Abutment supported retainer - porcelain fused to titanium and titanium alloys. Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	
The following service is not subject to a frequency limit.	40%

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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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Removal of implant body not requiring bone removal nor flap elevation. Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	
The following services are limited to one every 36 months. Guided tissue regeneration – resorbable barrier, per implant. Guided tissue regeneration – non-resorbable barrier, per implant.	40%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
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 disabling 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. Limited orthodontic treatment of the primary dentition. Limited orthodontic treatment of the transitional dentition. Limited orthodontic treatment of the adolescent dentition. Comprehensive orthodontic treatment of the transitional dentition. Comprehensive orthodontic treatment of the adolescent dentition. Removable appliance therapy. Fixed appliance therapy.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-Payment.**
Pre-orthodontic treatment visit. Periodic orthodontic treatment visit. Orthodontic retention. Removal of fixed orthodontic appliances for reasons other than completion of treatment. Repair of orthodontic appliance - maxillary. Repair of orthodontic appliance - mandibular. Re-cement or re-bond fixed retainer - maxillary. Re-cement or re-bond fixed retainer - mandibular. Repair of fixed retainer, includes reattachment - maxillary. Repair of fixed retainer, includes reattachment - mandibular.	

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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 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.

Annual Deductible

Unless otherwise stated in the below *Schedule of Benefits*, Benefits for pediatric Vision Care Services provided under this section are subject to the Annual Deductible stated in the medical *Schedule of Benefits*.

Out-of-Pocket Limit - any amount you pay in Co-payments for Vision 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.

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 Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		40%
• Bifocal		40%
• Trifocal		40%
• Lenticular		40%
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Tinted Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.

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Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Oversized Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Blended Segment Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Intermediate Vision Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Standard Progressives		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Premium Progressives		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Photochromic Glass Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Plastic Photosensitive Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Polarized Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Hi-index Lenses		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Standard Anti-Reflective Coating		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Premium Anti-Reflective Coating		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Ultra Anti-reflective Reflective Coating		80% of the billed charge. Not subject to payment of the Annual Deductible.
• Ultraviolet Protective Coating		80% of the billed charge. Not subject to payment of the Annual Deductible.
Eyeglass Frames	Once every 12 months.	

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Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Eyeglass Frames with a retail cost up to $130.		40%
• Eyeglass Frames with a retail cost of $130 - 160.		40%
• Eyeglass Frames with a retail cost of $160 - 200.		40%
• Eyeglass Frames with a retail cost of $200 - 250.		40%
• Eyeglass Frames with a retail cost greater than $250.		40%
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Covered Contact Lens Formulary	Limited to a 12 month supply.	40%
Necessary Contact Lenses	Limited to a 12 month supply.	40%
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 Not subject to payment of the Annual Deductible.
• Low Vision Therapy		25% of billed charges. Not subject to payment of the Annual Deductible.

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What Is the Policy?

This Policy is a legal document between UnitedHealthcare of Illinois, Inc. and you 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, 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 Illinois. This Policy is governed by Illinois law.

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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 Illinois, 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. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

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

Choose Your Physician

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

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. 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*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment 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 or Co-payment 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.

File Claims with Complete and Accurate Information

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

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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

Benefits Review

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

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

- Establish the Benefits and the other terms, limitations and exclusions set out in this Policy, the Schedule of Benefits and any Amendments.
- Make factual findings related to Benefits.

We may give this authority to other individuals or organizations that 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 at our discretion. 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

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

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

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

If specific Covered Health Care Services are not available from a Network Provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network Providers. In this situation, your Network Physician or Primary Care 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 or Primary Care Physician to coordinate care through an out-of-Network Provider. You will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or Provider for Allowed Amounts.

Emergency Services Incurred by Out-of-Network Providers

For Emergency Health Care Services, you will not incur any greater out-of-pocket costs than you would have incurred with a Network Physician or Provider for Allowed Amounts. No prior authorization is required for emergency services.

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

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other Providers in our Network through our Provider website. Network Physicians and Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or Provider 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 *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.

Coverage of the outpatient facility fee is listed in the attached Schedule of Benefits and under the following within this section: Lab, X-Rays and Diagnostic - Outpatient, Major Diagnostic and Imaging - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic, and Surgery - Outpatient. The facility charge and the charge for supplies and equipment are included Benefits for these outpatient procedures.

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 and/or Co-payment).
- 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."

Abortion Care Services

Abortion Care Services, including both elective and therapeutic, procedural Abortion Care Services without restrictions or delays. Medications that are obtained through a prescription and used to terminate a pregnancy, regardless of whether there is proof of a pregnancy, are covered under the Outpatient Prescription Drugs section of this Policy.

Ambulance Services

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

“Urgent ground ambulance service" means transportation by ground ambulance that a health care professional determines is Medically Necessary and must occur within 12 hours after the need is confirmed.

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

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.

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- 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.

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.
  - 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, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

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

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

Dental Anesthesia

Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or ambulatory surgical facility if:

- A child is age 6 and under,
- You have a chronic disability, or
- You have a medical condition requiring hospitalization or general anesthesia for dental care.

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

- Is under age 26; and
- Has been diagnosed with an Autism Spectrum Disorder or a disability.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.

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

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

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

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

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

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

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 for, orthopedic shoes, inserts, modifications, and footwear when Medically Necessary for the treatment of complications related to diabetes.

Diabetic Self-Management Supplies

Benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and glucose tablets, and single measurement glucose monitors, including those for the legally blind, 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)*. Eligible members can receive continuous glucose monitors (CGMs) and related supplies for insulin-treated diabetes without prior authorization and with no cost-share for a 30-day supply, including one transmitter if necessary.

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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.

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.

DME includes, but isn't limited to:

- Canes.
- Cardiopulmonary monitors.
- 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.
    - Medically Necessary repairs to a complex manual wheelchair do not require prior authorization, medical documentation, or proof of continued need unless:
        - The repairs are covered under a manufacturer's warranty.
        - The cumulative cost of the repairs exceeds 75% of the cost to replace the wheelchair.
        - The wheelchair in need of repair is subject to replacement because the wheelchair age exceeds or is within one year of expiration of the five-year reasonable useful life of the wheelchair.
    - Benefits for a rental wheelchair are available during the time the primary complex wheelchair is being repaired.
    - If a repair is done on a part of your wheelchair that was not covered when you first received it, and it is determined that the repair was not Medically Necessary during a post-service review, you will not be responsible for the cost of the repair and the supplier who performed the repair will be liable for the cost.
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

Ostomy supplies are covered and limited to the following:

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

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- Skin barriers.

Note: Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, 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.*

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. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

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

Examination and Treatment for Sexual Assault

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

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.

Benefits include amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome when prescribed by a Physician.

Human Breast Milk

Benefits include pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed Physician, for:

- Covered Persons under the age of 6 months, when all of the following conditions are met.
  - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.
  - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
  - The infant's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
  - One or more of the following applies:
    - The infant's birth weight is below 1,500 grams.
    - The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
    - The infant has infant hypoglycemia.
    - The infant has congenital heart disease.

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        - The infant has had or will have an organ transplant.
        - The infant has sepsis.
        - The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the infant.
- Covered Persons 6 months through 12 months of age, when all of the following conditions are met.
    - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.
    - The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
    - The child's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated.
    - One or more of the following applies:
        - The child has spinal muscular atrophy.
        - The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
        - The child has had or will have an organ transplant.
        - The child has a congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the child.

Fertility Preservation for Iatrogenic Infertility

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

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

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

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

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician. Covered medical and behavioral health services may not be denied solely because the diagnosis is gender dysphoria.

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

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. Benefits will be determined 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, including children with congenital, genetic, or early acquired disorders, are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.

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- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.
- Treatment for Autism Spectrum Disorders, including therapies that provide treatment in self-care and feeding, pragmatic, receptive, and expressive language, cognitive functioning, motor planning, and sensory processing.

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.
- 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.

Visit limits do not apply.

Benefits will not be denied based solely on the location of where the Medically Necessary services are rendered.

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 to Covered Persons of any age, and are limited to one hearing instrument (hearing aid) per hearing impaired ear every three years, for a hearing aid that is purchased due to a written recommendation by a Physician.

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.

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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.

Bone anchored hearing aids are described under *Surgery - Outpatient*. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this 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.

Cochlear implants are not hearing aids. Benefits under this category do not include bone anchored hearing aids

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, 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.

Private Duty Nursing

Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature.

Hospice Care

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

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.
- Pediatric palliative care, including community-based pediatric palliative 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, including stays in an intensive care unit.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay, including anesthesia services, regardless of the duration.
- Room and board in a private room or a Semi-private Room (a room with two or more beds).
- 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*.)
- A stay following a covered mastectomy for the length of time determined as medically appropriate by the attending Physician and in accordance with the protocols and guidelines based on sound scientific evidence and upon evaluation of the Covered Person and the availability of a post-discharge Physician's office visit or in-home nurse visit to verify the condition of the Covered Person in the first 48 hours after discharge.

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Infertility Treatment

Coverage is provided for the diagnosis and/or treatment of Infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and fertility preservation.

- Coverage includes procedures necessary to screen or diagnose a fertilized egg before implantation, including, but not limited to:
  - Preimplantation genetic testing for aneuploidy.
  - Preimplantation genetic testing for chromosome structural rearrangements.
  - Preimplantation genetic testing for monogenic or single gene disorders.

This coverage is subject to the following conditions:

- Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:
  - the Covered Person has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments for which coverage is available under the policy, plan, or contract;
  - the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered; and
  - the procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.
- Coverage for treatments that include oocyte retrievals will be provided only when:
  - You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
  - You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

The maximum number of completed oocyte retrievals that are eligible for coverage under this Policy in your lifetime is six. Following the final completed oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no Benefits for Infertility treatment.

Benefits for expenses of an oocyte or sperm donor:

The medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the covered recipient shall be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, shall also be covered if established as prerequisites to donation by us. If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count against the Covered Person as one completed oocyte retrieval.

Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits 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*.)

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- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
- Medically Necessary molecular oncology testing and biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring. Benefits will be the same as those described under each Covered Health Care Service category in Section 1: *Covered Health Care Services*.

  If a Provider submits a pre-service request for Benefits (prior authorization) for molecular oncology testing or biomarker testing and the request is denied, you or your authorized representative may request an appeal of the adverse determination in accordance with *Section 6: Questions, Complaints and Appeals*. An appeal is a request to change a previous Benefit determination and must be submitted within the timeframes and in the manner described in this Policy. You may submit an appeal by completing the appropriate Member Service Request Form, available by signing in to your member account or by accessing the "Member Forms" Member forms | UnitedHealthcare section of the UnitedHealthcare website and selecting the Appeals and Grievance Medical and Prescription Drug Request Form: https://memberforms.uhc.com/Memberappealsandgrievances.html.
- Comprehensive cancer testing and testing of blood or constitutional tissue for cancer predisposition testing determined to be Medically Necessary by a Physician licensed to practice medicine in all its branches.
- Vitamin D testing in accordance with vitamin D deficiency risk factors identified by the *United States Centers for Disease Control and Prevention*.
- Karotype testing or related hormone testing to diagnose Klinefelter syndrome.
- Medically Necessary diagnostic services used in the evaluation of Alzheimer's disease or related dementias, including labs.
- Medically Necessary diagnostic services used in the evaluation of Alzheimer's disease or related dementias, including neuroimaging.
- Home saliva cancer screening: an outpatient test that uses your saliva to detect biomarkers for early-stage cancer every 24 months if you:
  - Are asymptomatic and at high risk for the disease being tested for; or
  - Demonstrate symptoms of the disease being tested for at a physical exam.
- Peripheral Artery Disease Screening tests for any at-risk individual.
- Medically Necessary pancreatic cancer screening.

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, 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 Treatment

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services.

Benefits are limited as described in the Schedule of Benefits.

Naprapathic Services

Benefits will be provided for naprapathic services when rendered by a Naprapath.

SAMPLE

A Naprapath is a duly licensed individual who specializes in the treatment of disease by manipulation of joints, muscles, and ligaments, based on the belief that many diseases are caused by displacement of connective tissues. Naprapathic services include the performance of naprapathic practices by a Naprapath which may legally be rendered by them.

Benefits are limited as described in the Schedule of Benefits.

Mental Health Care and Substance Use Disorder Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health Care and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of 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.
- Tele-Psychiatry, as described under *Telehealth*.

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 and other associated treatments, including Opioid Medically Assisted Treatment (MAT). Products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder, Diagnosis of Autism Spectrum Disorders and Treatment for Autism Spectrum Disorders (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 applicable medical Covered Health Care Services categories in this Policy.

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

Inpatient Mental Health Care Services are not subject to prior authorization requirements. Inpatient Mental Health Care Services are not subject to concurrent review for the first 72 hours, provided your provider or facility provides

SAMPLE

notification of the admission and the initial treatment plan within 48 hours of admission. If your provider or facility fails to notify us of the initiation of treatment, we may follow our normal prior authorization processes.

Treatment may be reviewed retrospectively, and if denied retrospectively, you will not be liable, other than your cost share, for treatment through the date the adverse determination is issued. Coverage will not be retrospectively denied for the first 72 hours of treatment except upon:

- Reasonable determination that the inpatient mental health treatment was not provided.
- Determination that the patient receiving the treatment is not a Covered Person under the Policy.
- Material misrepresentation by the patient or health care provider.
- Determination that a service was excluded under the terms of coverage. In that case, you will be liable for all services.

Benefits also include:

- Services received on the same day from the same or different mental health or substance use provider or facility for both outpatient and inpatient care.
- Services provided by a behavioral health trainee, when the trainee is working toward clinical state licensure and is under the supervision of a fully licensed mental health or substance use disorder treatment provider.
- Medically Necessary 60-minute psychotherapy for individual therapy.

Reimbursement for food, lodging and travel may be available for a Covered Person who has received a Network exception to obtain Mental Health Care and Substance Use Disorders Services by an out-of-Network provider.

Mobile Integrated Health Care Services

Benefits include services to an eligible recipient for Medically Necessary Mobile Integrated Health Care Services.

For this Benefit an eligible recipient means a Covered Person who has received Hospital Emergency department services three or more times in a period of four consecutive months in the past 12 months or a Covered Person who has been identified by a health care provider as an individual for whom Mobile Integrated Health Care Services would likely prevent admission or readmission to or would allow discharge from a Hospital, behavioral health facility, acute care facility, or nursing facility. Services do not include non-Emergency ambulance transport.

Mobile Integrated Health Care Services for this Benefit is defined as health care services provided on-site by Emergency medical services personnel, as defined in *Section 5* of the *Emergency Medical Services (EMS) Systems Act*. Services include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures as approved by the applicable EMS Medical Director.

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).

Neuromuscular, Neurological, or Cognitive Impairment Treatment

Benefits include services for therapy, diagnostic testing, and equipment necessary to increase the quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Orthotics

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

SAMPLE

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.

Benefits also include an additional custom orthotic device or prosthetic device that is determined by your provider to be the most appropriate model for you to perform physical activities such as running, biking, swimming, and lifting weights, to maximize whole body health and strengthen the lower and upper limb function.

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

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

If you/your Provider are directed to a Designated Dispensing Entity and you/your Provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product, unless the provider or its intermediary agrees in writing to accept reimbursement, including Co-payment, at the same rate as a Designated Dispensing Entity.

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.

Physician Fees for Surgical and Medical Services

Physician, assistant surgeon and surgical assistant 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 cause of infertility. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.
- Benefits delivered through the psychiatric Collaborative Care Model.

SAMPLE

The term "psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method, which includes a formal collaborative arrangement among a primary care team consisting of a primary care Provider, a care manager, and a psychiatric consultant, and includes, but is not limited to, the following elements:

- Care directed by the primary care team;
- Structured care management;
- Regular assessments of clinical status using validated tools; and
- Modification of treatment as appropriate.

- Treatment for tick-borne disease. Treatment may include office visits, ongoing testing, and antibiotic therapy. Benefits will be Benefits will be the same as those described under each Covered Health Care Service category in Section 1: *Covered Health Care Services*.

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. Coverage includes postpartum services received within the first 12 months after the pregnancy ends. Network Benefits are available at no cost share.

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

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

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

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

If you are experiencing a high-risk pregnancy, a case management program is available to assist you. Case management is a collaborative process designed to coordinate and support your care and help ensure continuity of services throughout your pregnancy and postpartum period.

Case management services may include, but are not limited to:

- An individualized assessment of your health care and support needs;
- Development and coordination of a plan of care in collaboration with you, your family or caregivers (as appropriate), and your treating provider(s);
- Assistance with referrals to appropriate health care, social, and community-based services;
- Monitoring of your progress and ongoing care needs; and
- Advocacy to help you access medically appropriate services and support.

Case management is provided by a qualified case manager and is an active, ongoing, and collaborative process involving you and your care team. Services are available to support you throughout your pregnancy and will conclude when your care needs related to the pregnancy have been addressed.

You may contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information about this program.

SAMPLE

Benefits are available if you are experiencing a mental, emotional, nervous, or substance use disorder or condition related to Pregnancy or postpartum complications. Benefits for these services are described under *Mental Health Care and Substance Use Disorders Services*. Network Benefits are available at no cost share for outpatient mental health services and substance use disorders for levels of treatment below Level 3.1 (Clinically Managed Low-Intensity Residential), as established by the *American Society for Addiction Medicine*.

Benefits for Pregnancy, postpartum, and newborn care rendered from perinatal doulas or licensed certified professional midwives include services for home births, home visits, and support during labor, abortion, or miscarriage. Home visits by a perinatal doula are limited to 16 visits before and 16 visits after a birth, miscarriage, or abortion for each pregnancy and postpartum period. Network Benefits for services provided by midwives for home visits, and labor, abortion, or miscarriage support are available at no cost share.

Benefits for the necessary equipment and medical supplies for a home birth are provided under the applicable Benefit category in this Policy. Benefits include prenatal HIV testing when ordered by an attending Physician, a physician assistant, or an advanced practice registered nurse. Orders must be consistent with the recommendations of the *American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.*

Benefits also include two at-home, urine-based pregnancy tests that are prescribed to the Covered Person, regardless of whether the tests are otherwise available over-the-counter.

Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including the administration of the vaccine by a pharmacist or health care provider authorized to administer such a vaccine.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Contraceptive devices, including the insertion or removal of, and any Medically Necessary consultations, examinations, or procedures associated with, the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives. Benefits include voluntary female sterilization and associated anesthesia.
- Clinical breast exams when done as part of a preventive exam.
- Tobacco use screening for all adults and cessation interventions for tobacco users.

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.

Illinois Mandated Preventive Health Care Services

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

- Vaccinations listed in the *Illinois Department of Public Health (IDPH) Guidance,* including the administration of the vaccine by a pharmacist or health care provider authorized to administer such a vaccine.
- Contraceptive services
    - Contraceptive drugs, devices, and other products approved by the *FDA*. Including all *FDA*-approved methods of over-the-counter drugs, devices, and products. Note that contraceptive medications which you obtain from a pharmacy are covered under the *Outpatient Prescription Drugs* section of this Policy.

SAMPLE

- Contraceptive services, patient education, and counseling on contraception.
- Follow-up services related to contraceptive drugs, devices, products, and procedures.
- Voluntary male sterilization and associated anesthesia.

- Screening by Low-dose Mammography which includes, but is not limited to:
  - A baseline mammogram for Covered Persons who are 35-39 years of age.
  - An annual mammogram for Covered Persons age 40 and over.
  - A mammogram at the age and intervals considered to be Medically Necessary by the Covered Person's Physician for Covered Persons under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
  - A comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.
  - A screening MRI when Medically Necessary, as determined by a Physician licensed to practice medicine in all of its branches.
- Diagnostic mammography, which includes a screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast. Treatment and follow-up testing for fibrocystic breast conditions is available and benefits will be the same as those described under each Covered Health Care Service category in Section 1: *Covered Health Care Services*.
- One annual office visit for a whole body skin examination for lesions suspicious for skin cancer.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women. Services include home visits by lactation consultants.
- An annual prostate cancer screening including a digital rectal exam and a prostate specific antigen test and associated laboratory work upon the recommendation of a Physician for any of the following:
  - Asymptomatic Covered Persons age 50 and over.
  - African-American Covered Persons age 40 and over.
  - Covered Persons age 40 and over with a family history of, or genetic predisposition to, prostate cancer.
- Genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer if recommended by a health care provider in accordance with the *United States Preventive Services Task Force's* recommendations for testing.
- An annual cervical smear or Pap smear test.
- A1C testing for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with prediabetes and diabetes risk factors identified by the *United States Centers for Disease Control and Prevention.*
- Follow-up services related to coverage for abortifacients, hormonal therapy to treat gender dysphoria, and human immunodeficiency virus (HIV) pre-exposure prophylaxis and post-exposure prophylaxis.
- Liver disease screening for Covered Persons between the ages of 35 and 65 at high risk for liver disease. Benefits include liver ultrasounds and alpha-fetoprotein blood tests every six months.
- Osteoporosis screening, including bone mass measurement, for women over age 60, depending on risk factors.
- One annual menopause health visit for Covered Persons age 45 years or older.
- Annual Surveillance tests for individuals who are at risk for ovarian cancer, which includes individuals with one or more first-degree relatives with ovarian cancer, clusters of relatives with breast cancer, positive BRCA1 or BRCA2 mutations, or nonpolyposis colorectal cancer Surveillance tests include:
  - CA-125 serum tumor marker testing.
  - transvaginal ultrasound.
  - pelvic examination.

SAMPLE

- Herpes Zoster Immunization (shingles).
- Human Papillomavirus Immunization (HPV).

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

Benefits also include one annual mental health prevention and wellness visit of up to 60 minutes for children and adults. Services must be performed by a Physician, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed social worker, or a licensed professional counselor. This visit is in addition to any annual physical exam, and there is no cost share requirement.

Prosthetic Devices

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

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

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

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 also include an additional prosthetic device determined by your provider to be the most appropriate model for you to perform physical activities such as running, biking, swimming, and lifting weights, to maximize whole body health and strengthen the lower and upper limb function.

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

Covered Health Care Services also include a wig or hair prosthesis for Covered Persons with hair loss caused by alopecia, Chemotherapy, or radiation treatment for cancer or other conditions. Benefits are limited as described in the *Schedule of Benefits*.

Reconstructive Procedures

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

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.
- Medically Necessary treatment performed on structures of the body damaged by trauma to restore physical appearance.

Reconstructive procedures include surgery or other procedures which are related to an Injury, trauma, Sickness or Congenital Anomaly. Microtia repair is considered a reconstructive procedure.

Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child or Medically Necessary breast reduction surgery. 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.

Benefits are available for the care and treatment of cleft lip and cleft palate. Benefits include oral and facial surgery; prosthetic treatment; orthodontic, prosthodontic, and otolaryngology treatment and management. Benefits do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance.

SAMPLE

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, including compression sleeves, 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.

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

Port-Wine Stain Treatment

Benefits include treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including but not limited to, port-wine stains caused by Sturge-Weber syndrome.

For purposes of this Benefit, treatment or maximum feasible treatment includes early intervention treatment, including topical, intralesional, or systemic medical therapy and surgery, and laser treatments approved by the *U.S. Food and Drug Administration* for Covered Persons aged 18 years and younger. These are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications associated with port-wine stains.

Benefits include Medically Necessary services for Covered Persons over 18 years of age. Benefits do not include treatment solely for cosmetic purposes.

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Preventive physical therapy for multiple sclerosis.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Rehabilitation services must be performed by a Physician or by a licensed therapy Provider. Benefits are also available for hippotherapy that incorporates equine movement as part of a therapeutic intervention when performed by a licensed occupational therapist, physical therapist, or speech pathologist in conjunction with a professional horse handler and therapy horse. 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.

Visit limits do not apply.

Benefits are not available for maintenance/preventive treatment.

SAMPLE

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:

- Sigmoidoscopy.
- Diagnostic endoscopy.
- Colonoscopy, including a follow-up exam based on an initial screen where the colonoscopy was determined to be medically necessary.
- Medically Necessary colonoscopies are available without cost share.
- Colorectal cancer screenings are covered in accordance with the published *American Cancer Society* guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by the nationally recognized professional medical societies or federal government agencies, including the *National Cancer Institute*, the *Centers for Disease Control and Prevention*, and the *American College of Gastroenterology*. Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services.*

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*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Benefits are available for:

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

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

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

Benefits will be determined 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, including anesthesia services regardless of the duration, 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:

SAMPLE

- 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 fees of your surgeon, are described under *Physician Fees for Surgical and Medical Services*.)
- 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.

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 Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

Oral Surgery

Benefits include:

- Surgical removal of complete bony impacted teeth.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts.
- Associated anesthesia services, regardless of duration.

Telehealth Services

Benefits are provided for services delivered via Telehealth by health care professionals, including licensed dietitians, nutritionists and certified diabetes educators who counsel senior diabetic Covered Persons in the home. Benefits are also provided for Remote Physiologic Monitoring. Benefits also include tele-psychiatry care. Benefits for these services are provided to the same extent and will not exceed the applicable cost share as an in-person service under any applicable Benefit category in this section.

An in-person consultation is not required prior to receiving Telehealth services. If you prefer an in-person consultation instead of Telehealth services, Benefits are available under the applicable Benefit category in this section.

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.

SAMPLE

- Developmental defect.
- Pathology.

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, including proton beam therapy.
- Breast cancer pain therapy. Cost share may vary depending upon the type of service and where it is received. Medically Necessary breast cancer pain medication is covered under *Section 10: Outpatient Prescription Drugs*.

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*.

Benefits also include the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome (PANDAS/PANS. Long-term antibiotic therapy for and tick-borne diseases is covered, including experimental drugs used off-label to treat tick-borne disease as approved by the United States Food and Drug Administration. Some drugs may be covered under *Section 10: Outpatient Prescription Drugs*.

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.

Examples of transplants for which Benefits are available include:

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

SAMPLE

- Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under this Policy, limited to donor:
- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

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

Travel and Lodging

Benefits include transportation and lodging for the covered patient receiving transplant and a companion.

If the recipient of the transplant is a dependent child under the limiting age of this Policy, Benefits for transportation and lodging will be provided for the transplant recipient and two companions.

For Benefits to be available, the patient's place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

Urgent Care Center Services

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

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com/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).

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*.

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 as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

Exclusions herein do not apply to Benefits covered under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

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

   This exclusion does not apply to dental care (oral exam, X-rays and other imagine 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, cleft palate or cleft lip.

SAMPLE

- Dental anesthesia for which Benefits are provided as described under *Dental Anesthesia* in *Section 1: Covered Health Care Services*.
- Oral surgery for which Benefits are provided under *Surgery - Outpatient* in *Section 1: Covered Health Care Services.*

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.
3. Dental implants, bone grafts and other implant-related procedures.
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. This does not include prosthetic or custom orthotic devices necessary for a Covered Person to perform physical activities such as running, biking, swimming, and lifting weights.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Diabetes Services, Durable Medical Equipment (DME),* and *Orthotics* and 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, except as described under Durable Medical Equipment in *Section 1: Covered Health Care Services.*
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Powered wheelchairs.

SAMPLE

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. See the *Outpatient Prescription Drugs* section of this Policy for prescription drug products covered under the pharmacy benefit.
2. Self-administered or self-infused medications that are covered under the *Outpatient Prescription Drugs* section. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness 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.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to monthly.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to monthly.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to monthly.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly.
11. 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 an Experimental or Investigational Service 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.
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.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - 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 *Durable Medical Equipment (DME)* 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, and standard milk-based formula. 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.
   - 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, except as described under *Reconstructive Services* in *Section 1: Covered Health Care Services*. 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.
   - Sclerotherapy treatment of veins.

SAMPLE

- Hair removal or replacement by any means. This exclusion does not apply to medically necessary laser hair removal that is prescribed as a medical treatment and aligns with generally accepted standards of medical care.
- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- 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.

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.
7. The following services for the diagnosis and treatment of Temporomandibular Joint Syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
8. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.

SAMPLE

9. 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 is requested to treat 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.*
10. Helicobacter pylori *(H. pylori)* serologic testing.
11. Intracellular micronutrient testing.
12. Morbid Obesity Surgery not received at a Designated Provider.

Providers

1. Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
2. Services performed by a Provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other Provider. Services which are self-directed to a Freestanding Facility or 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. The following Infertility treatment-related services:
   - Donor services, except those described under *Infertility Services* in *Section 1: Covered Health Care Services*.
2. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assisted reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.
     - Travel or transportation fees.
3. Non-medical costs of donor eggs and donor sperm.

SAMPLE

4. The reversal of voluntary sterilization, however, in the event a voluntary sterilization is successfully reversed, Infertility Benefits shall be available if the covered individual's diagnosis meets the definition of "Infertility" as defined in *Section 8: Defined Terms*.
5. In vitro fertilization regardless of the reason for treatment, except as may be specifically provided for in *Section 1: Covered Health Care Services*, *Infertility Services*.
6. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to Benefits described under *Fertility Preservation for Iatrogenic Infertility* in *Section 1: Covered Health Care Services*.
7. Elective fertility preservation except as described under *Fertility Preservation for Iatrogenic Infertility* 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. Inpatient Private Duty Nursing and one-on-one Private Duty Nursing, except as described under *Home Health Care*.
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.

SAMPLE

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).
11. Transitional Living services (including recovery residences).

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).
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. 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 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 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 Covered Person 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. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network Provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
12. 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 state's official health insurance marketplace, Get Covered Illinois®, available at getcovered.illinois.gov. 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 state's health insurance marketplace, Get Covered Illinois® 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 state's health insurance marketplace, Get Covered Illinois®. 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 state's health insurance marketplace, Get Covered Illinois®.

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 state's health insurance marketplace, Get Covered Illinois®.

Coverage begins on the date determined by the state's health insurance marketplace, Get Covered Illinois® 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 state's health insurance marketplace, Get Covered Illinois®.

Adding New Dependents

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

SAMPLE

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Civil Union.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

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

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

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

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.

If Premium payments are not made as required:

- Your coverage will end as described in *Section 4: When Coverage Ends*, under *What Events End Your Coverage?* and *Other Events Ending Your Coverage*.
- In order to enroll in a new plan after terminating for non-payment, as allowed under federal law, we may require that your re-enrollment be subject to:
  - Your payment in full of any past due premiums owed to us within the last 12 months.
  - Payment of the first month’s premium for the new plan.

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 the state's health insurance marketplace, Get Covered Illinois® of your new residence. Your Premium will be based on your new residence beginning on the date determined by the state's

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health insurance marketplace, Get Covered Illinois®. 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.

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 mentioned below in *What Events End Your Coverage* or *Other Events Ending Your Coverage* occur.

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 state's health insurance marketplace, Get Covered Illinois® 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 state's health insurance marketplace, Get Covered Illinois®. 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 state's health insurance marketplace, Get Covered Illinois® rules if we receive notice from the state's health insurance marketplace, Get Covered Illinois® instructing us to end your coverage.

  Your coverage ends on the date determined by the state's health insurance marketplace, Get Covered Illinois® rules if we receive notice from you instructing us to end your coverage.

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.

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- **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 a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

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

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

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 state's health insurance marketplace, Get Covered Illinois®.

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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 to a Network Provider.

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

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

Notice of Claim

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

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under Required Information.

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 of the date we receive proof of loss. If we fail to pay within 30 days, you are entitled to interest at the rate of nine percent per annum from the 30th day after receipt of proof of loss.

Assignment of Benefits

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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 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 Appropriations Act (P.L. 116-260)* are paid directly to the provider. An out-of-Network provider, subject to the *No Surprises Act*, may negotiate reimbursement after initial payment is received. If attempts to negotiate reimbursement do not result in a resolution of the payment dispute within 30 days after receipt of the explanation of benefits, then UnitedHealthcare or the out-of-Network provider or facility may initiate binding arbitration. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the non-requesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the *Department of Insurance*.

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

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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-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?

A complaint is an expression of dissatisfaction.

You may call (urgent only) or write to us to file a complaint about quality of service and quality of care that you received.

We will acknowledge, in writing, receipt of your complaint within 10 business days and request all the information required to evaluate your case. We will notify you of our decision regarding your complaint within 60 calendar days of receiving it.

You may file a consumer complaint online at the Illinois Department of Insurance's (DOI) website or by mail. The DOI maintains a Consumer Division in Chicago and Springfield at the contact information shown below:

Illinois Department of Insurance

115 S. LaSalle Street, 13th Floor

Chicago, IL 60603

Phone: (312) 814-2420

Illinois Department of Insurance

Office of Consumer Health Insurance

320 West Washington St.

Springfield, IL 62767

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Phone: (217) 782-4515

Fax number: (217) 558-2083

Toll-free Telephone: (877) 527-9431

Email: DOI.complaints@illinois.gov

Website: https://idoi.illinois.gov/consumers/file-a-complaint

How Do You Appeal a Decision?

An appeal is a request from you to change a previous claim or benefit decision. There are two types of appeals:

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, a rescission of coverage determination or Prescription Drug Products determination as described under the *Outpatient Prescription Drugs* section of this Policy, you can contact us verbally (urgent only) or in writing to request an appeal.

Your request for an appeal should include:

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

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

Internal Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. By submitting an appeal, you consent to this referral and the sharing of the medical claim information needed. Upon request and free of charge, you have the right to reasonable access to copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge prior to the due date of the response to the adverse benefit determination.

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

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

You will be notified orally of the decision and written notice will be sent following oral notification.

Appeals Determinations

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

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Appeal Type	Response Time from Receipt of Request
Pre-service request for Benefit appeals	15 business days
Post-service claim appeals	15 business days

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

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

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you orally of the decision within 24 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. Written notice will be sent following oral notification.
- If we need more information from your Physician to make a decision, we will notify you orally of the decision within 24 hours following receipt of the required information. Written notice will be sent following oral notification.

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

Exhaustion of Internal Appeal Process

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

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

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

Standard External Review (including Experimental and Investigational Treatment Reviews)

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

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

Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield, IL 62767

Toll Free phone number: (877) 850-4740

Fax number: (217) 557-8495

Email address: doi.externalreview@illinois.gov

Website: https://idoi.illinois.gov/consumers/file-an-external-review

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

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

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

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

Within one business day after completing the preliminary review, we will provide written notice to you and the *DOI* indicating whether the request is complete and eligible for external review. If incomplete, we will notify you and the *DOI* of any missing information needed to complete the request. If ineligible, we will explain the reasons for ineligibility for external review and notify you and the *DOI* that you may file a complaint regarding our decision to the *DOI*. The *DOI* is authorized to reverse our initial determination and require that the request be referred for external review.

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

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

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

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

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

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

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

Expedited External Review including Investigational Treatment Reviews

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

- Immediately after receiving a notice of adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or
  - The adverse determination is based on the service being determined experimental or investigational, and your Provider certifies that the service would be significantly less effective if not promptly initiated; an expedited external review may be requested at the same time you or your authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether you are required to complete the expedited review of the appeal prior to conducting the expedited external review.
- Immediately after receiving a notice of final adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for a standard external review;
  - The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received Emergency Health Care Services but have not been discharged from the facility, then you or your authorized representative, may request an expedited external review;
  - The final adverse determination is based on the service being determined experimental or investigational, and your Provider certifies that the service would be significantly less effective if not promptly initiated; or
  - We fail to provide a decision on an expedited internal appeal within 24 hours.

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

The request must meet the following reviewability requirements:

- You were a Covered Person at the time services were requested or provided;

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

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

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

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

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

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

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

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

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

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

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

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

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- For experimental or investigational treatment reviews, descriptions of the factors considered by the independent review organization in making its decision.

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

Independent Review Organization

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

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

Appeals to the Department of Insurance

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

To file a Complaint:

Illinois Department of Insurance

115 S. LaSalle Street, 13th Floor

Chicago, IL 60603

Phone: (312) 814-2420

Illinois Department of Insurance

Office of Consumer Health Insurance

320 West Washington Street

Springfield, IL 62767

Phone: (217) 782-4515Fax number: (217) 558-2083

Toll Free phone number: (877) 527-9431

Email address: DOI.complaints@illinois.gov

Website: https://idoi.illinois.gov/consumers/file-a-complaint

For External Requests and Questions:

Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield, IL 62767

Toll Free phone number: (877) 850-4740

Fax number: (217) 557-8495

Email address: doi.externalreview@illinois.gov

Website: https://idoi.illinois.gov/consumers/file-an-external-review

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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 health care treatments you or your Physician may believe are needed. Benefits are limited to Covered Health Care Services. 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.

Continuation of Care

If you are undergoing treatment from a Network provider at the time the provider is terminated without cause, you will be allowed to continue treatment at the Network Benefit level until the treatment is complete or for 90 days, whichever is shorter. This includes an individual who, with respect to a provider or a facility:

- Is undergoing an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
- Is undergoing an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Covered Person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility.
- Is undergoing an ongoing course of treatment for a health condition for which a treating Physician or health care provider attests that discontinuing care by that Physician or healthcare provider would worsen the condition or interfere with anticipated outcomes.
- Is scheduled to undergo non elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

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, 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.

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- 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.
- 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 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 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 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.

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Who Has Authority Over Benefits and Other Provisions under the Policy?

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

- Define the Benefits available under this Policy.
- Set the terms, conditions, limitations and exclusions outlined in this Policy, including those in the *Schedule of Benefits* and any Amendments.
- Make factual findings 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 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, 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.

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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.

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.

Subrogation and Reimbursement

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

Subrogation

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

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

Subrogation Example:

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

Right of Reimbursement

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

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

Reimbursement Example:

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

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- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
- Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.

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

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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.

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

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

Is There a Limitation of Action?

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

What Is the Entire Policy?

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

Abortion Care Services - services for which your provider may prescribe medicine, do an in-office procedure, or refer you for a procedure to terminate or end a pregnancy.

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 Use Disorder Services on an outpatient or inpatient basis.

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

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

- Related to emergency medicine, anesthesiology, pathology, radiology and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary;
- Provided by an out-of-Network Physician when no other Network Physician is available; and
- Provided by an out-of-Network Physician if there is no Network Physician who will provide services because the Network Physician has asserted his or her rights under the *Health Care Right of Conscience Act*.

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.

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

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

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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.

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.

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

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 or percentage of the Allowed Amount or the Recognized Amount when applicable, 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, or pending adoption.
- A foster child.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

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- The definition of a Dependent also includes parents or stepparents of the Policyholder or the Policyholder's spouse who meet the federal definition of a qualifying relative and lives or resides within the service area.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the 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* with a disability or meets the following:
  - Any unmarried Dependent child under age 30 if the Dependent:
    - Is an Illinois resident,
    - Served as active or reserve member of any *U.S. Armed Forces*, and
    - Received release or discharge other than dishonorable discharge.

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

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.

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

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

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.

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Eligible Person - a person who meets the eligibility requirements determined by the state's health insurance marketplace, Get Covered Illinois®. An Eligible Person must live within the Service Area.

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 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 Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), regardless of the final diagnosis given, such 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:
  - Inadequate time to complete a safe transfer to another Hospital before delivery; or
  - A transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

This definition is also in reference to the word "Emergency" as used throughout the Policy.

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

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

SAMPLE

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.

Exceptions:

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

    Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though experimental or investigational, 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.

SAMPLE

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. 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.

SAMPLE

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

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

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

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).*

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, two or more days per week.
- For Substance Use Disorder 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.

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.

SAMPLE

- 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 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 Use Disorder 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 (from *National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to 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.

SAMPLE

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-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits*, as part of your Policy, will tell you how the Out-of-Pocket Limit applies.

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

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

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

Please Note: 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.

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. A pharmacist is a Provider who is part of the Network and provides the same services as would be provided by a licensed Physician, an advanced practice registered nurse, or a physician assistant.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from the state's health insurance marketplace, Get Covered Illinois®.

SAMPLE

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

The amount is based on one of the following in the order listed below as applicable:

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

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

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

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

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.
- Medically Necessary treatment performed on structures of the body damaged by trauma to restore physical appearance.

Reconstructive procedures include surgery or other procedures which are related to an Injury, trauma, Sickness or Congenital Anomaly. 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 Use Disorder Services. It must meet all of the following requirements:

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

SAMPLE

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.

- Out of Service Area Coverage: If you are traveling outside of the service area, you have coverage for emergency services at any Emergency facility. If you require non-Emergency medical attention, you also have the option to seek care through any Urgent Care Center or Network convenience care clinic.

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:

- 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 Use Disorder 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 Use Disorder 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 - 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 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 two Physicians, of six months or less.

SAMPLE

Transitional Living - Mental Health Care Services and Substance Use Disorder 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).

Treatment for Autism Spectrum Disorders - includes the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by:

- A Physician licensed to practice medicine in all its branches.
- A certified, registered, or licensed health care professional with expertise in treating effects of

  Autism Spectrum Disorder when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:
  - Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
  - Psychological care, meaning direct or consultative services provided by a licensed psychologist.
  - Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an individual.
  - Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
    - Self-care and feeding.
    - Pragmatic, receptive, and expressive language.
    - Cognitive functioning.
    - Applied Behavior Analysis, intervention, and modification.
    - Motor planning.
    - Sensory processing.

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.

SAMPLE

Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

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

2. Plan does not include: Individual and group or group-type hospital indemnity benefits of $100 per day or less; hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; School accident-type coverages. These contracts cover elementary and secondary school students and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; A law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-government plan; Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; Medicaid policies; A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; and disability income protection coverage.

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

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

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

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

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred Provider arrangements.

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

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

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

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

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

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

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

SAMPLE

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

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

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

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

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

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

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

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

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

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

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this

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Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

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

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

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Section 10: Outpatient Prescription Drugs

Network

UnitedHealthcare of Illinois, Inc.

This section of the Policy provides Network Benefits for Prescription Drug Products.

Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under the heading *Defined Terms for Outpatient Prescription Drugs.*

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

NOTE: The Coordination of Benefits provision in Section 9: Coordination of Benefits applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in this Policy.

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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 factors. Clinical information 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. For changes that result in a drug moving to a higher tier or being removed from coverage, notice will be provided at least 60 days prior to this change. 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.

If a Generic drug or Therapeutic Equivalent is unavailable due to a supply issue and dosage cannot be adjusted, coverage will be provided for a Brand-name eligible Prescription Drug Product until supply of the Generic drug or Therapeutic Equivalent is available.

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 *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 any deductible that applies.

Submit your claim to:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Coupons, Incentives and Other Communications

We will apply any third-party payments, financial assistance, discounts, product vouchers, or any other reduction in out-of-pocket expenses made by you or on your behalf for prescription drugs toward your deductible, Co-payment, or cost sharing responsibility, or Out-of-Pocket Limit associated with your plan.

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

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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.

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 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 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.

Benefits are available for epinephrine delivery systems. An epinephrine delivery system is any form of epinephrine approved by the *FDA*, including any device containing a dose of epinephrine, and used to administer epinephrine into the human body to prevent or treat a life-threatening allergic reaction.

Immunosuppressant Drugs

Immunosuppressant drugs are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system as well as used to prevent the rejection of transplanted organs and tissues. When the prescribing Physician has indicated on the prescription "may not substitute", we will not require or cause a pharmacist to interchange another immunosuppressant drug or formulation unless we receive documented consent. Consent would be required of the prescribing Physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the person. Except for a change in the formulary as described below, Co-payments, deductibles, or other charges for the prescribed drug for which another immunosuppressant drug or formulation is not interchanged will remain the same for the remainder of the calendar year.

At least 60 days before we make any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or if we discontinue coverage for a prescribed immunosuppressant drug that a patient is receiving, we will, to the extent possible, notify the prescribing Physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change. It will indicate that the prescribing Physician may initiate an appeal, and will include information regarding the Policy's appeal process.

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, regardless of tier placement as described in the Policy under *Pharmaceutical Products - Outpatient* in *Section 1: Covered Health Care Services*.

Opioid Antagonists

Refer to the Prescription Drug List for covered Opioid Antagonists. Covered expenses include the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the Opioid Antagonist. Coverage includes refills for expired or utilized Opioid Antagonists included on the Prescription Drug List.

Benefits will be provided for at least one intranasal opioid reversal agent (Opioid Antagonist) prescription for initial prescriptions of opioids with dosages of 50 MME or higher.

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Acute and Chronic Pain

Benefits are provided for topical anti-inflammatory Prescription Drug Products approved by the *FDA* for acute and chronic pain.

Breast Cancer Pain Medication

Benefits are provided for all Medically Necessary pain medication related to the treatment of breast cancer.

Topical Eye Medications

Benefits for the early refill of a prescription for topical eye medication are available when:

- The medication is to treat a chronic condition of the eye.
- The refill is requested by the insurer prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use.
- The prescribing Physician licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested do not exceed the total number of refills prescribed.

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. The following conditions must be met:

(1) the Prescription Drug Products are covered by our Prescription Benefit policy or have been approved by a formulary exceptions process;

(2) the Prescription Drug Products are maintenance medications as defined by the policy and have available refill quantities at the time of synchronization;

(3) the Prescription Drug Products are not Schedule II, III, or IV controlled substances;

(4) the Covered Person meets all utilization management criteria specific to the Prescription Drug Products at the time of synchronization;

(5) the Prescription Drug Products are of a formulation that can be safely split into short-fill periods to achieve synchronization; and

(6) the Prescription Drug Products do not have special handling or sourcing needs as determined by the policy, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription.

When necessary to permit synchronization, a prorated daily cost-sharing rate will be applied to any medication dispensed by a Network Pharmacy. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

Abortion Care Services

Benefits include abortifacients and medications that are obtained through a prescription and used to terminate a pregnancy, regardless of whether there is proof of a pregnancy. Certain abortifacients at a Network Pharmacy may be covered at no cost share to you.

Hormonal Therapy

Hormonal Therapy for Gender Dysphoria

Benefits are provided for hormonal therapy medication administered to treat gender dysphoria from a Network Pharmacy at no cost share to you.

Hormone Therapy for Menopause Induced by Hysterectomy

Benefits include Prescription Drug Products for vaginal estrogen or its therapeutic equivalent when Medically Necessary hormone therapy treatment to treat menopause that has been induced by a hysterectomy.

Hormonal and Non-Hormonal Therapy for Menopausal Symptoms

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Benefits are also provided for Medically Necessary hormonal and non-hormonal therapy to treat menopausal symptoms when recommended by a qualified health care provider who is licensed, accredited, or certified under Illinois law and proven safe and effective in peer-reviewed scientific studies. Coverage for therapy to treat menopausal symptoms includes all FDA-approved modalities of hormonal and non-hormonal administration, including, but not limited to, oral, transdermal, topical, and vaginal rings.

HIV Pre-Exposure and Post-Exposure Prophylaxis

Benefits are provided for human immunodeficiency virus (HIV) pre-exposure prophylaxis and post-exposure prophylaxis from a Network Pharmacy at no cost share to you.

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 Drugs 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 Drugs 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 Drugs 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.

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 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

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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 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. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained when taken as prescribed.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained when taken as prescribed.
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 to be experimental or investigational. This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of a type of cancer for which the Prescription Drug Product has not yet been approved by the *FDA*, if the Prescription Drug Product is recognized for the specific treatment for which it was prescribed in a recognized peer-review medical publication or in one of the following established reference compendia: a) the American Hospital Formulary Service Drug Information; b) National Comprehensive Cancer Network's Drugs & Biologics Compendium; c) Thompson Micromedex's DrugDex; d) Elsevier Gold Standard's Clinical Pharmacology; e) other authoritative compendia as identified by the Federal Secretary of Health and Human Services or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
7. 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.
8. 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.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. 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.
11. 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.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride to prevent dental cavities in children.
13. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as a unit dose(s).
14. Prescription Drug Products used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

SAMPLE

17. 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.

18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 4.)

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or 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. This exclusion does not apply to over-the-counter *FDA*-approved contraceptive drugs, devices, and products as provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by Illinois law when prescribed by a Network Provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.

20. 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.

21. Growth hormone for familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) or idiopathic short stature (no known cause).

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. Dental products, including but not limited to prescription fluoride topicals.

27. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product) 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.

SAMPLE

28. Diagnostic kits and products, including associated services.
29. 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*.
30. 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.
31. Drugs to treat sexual dysfunction and/or impotency.

SAMPLE

Defined Terms for Outpatient Prescription Drugs

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.

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 by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL 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 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.

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.

SAMPLE

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.
- 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;
  - glucagon emergency kits;
  - *FDA*-approved oral agents used to control blood sugar; and
  - glucose meters.

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.

Synchronization - the coordination of medication refills for a Covered Person taking two or more medications for one or more chronic conditions that are refilled on the same schedule for a given time period.

Therapeutically Equivalent - when Prescription Drug Products 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 11: Pediatric Dental Care Services

Network

UnitedHealthcare of Illinois, Inc.

How Do You Use This Document?

This section of the Policy 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 Defined Terms?

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under *Defined Terms for Pediatric Dental Care Services.*

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

SAMPLE

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.

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 in *Pediatric Dental Exclusions* below.

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 *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 in this section under *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.

SAMPLE

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 Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. 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 procedure is considered to be an Experimental or Investigational Service 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. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
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 jaw bone 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 of the Policy.
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. Services rendered by a Provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered outside of the United States.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. 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.
26. 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.

SAMPLE

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 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.

SAMPLE

Section 12: Pediatric Vision Care Services

Network

UnitedHealthcare of Illinois, Inc.

How Do You Use This Document?

This section of the Policy 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.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in either *Section 8: Defined Terms* or in this section under the heading *Defined Terms for Pediatric Vision Care Services.*

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of Illinois, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in *Section 8: Defined Terms*.

SAMPLE

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-payments stated under each Vision Care Service in the *Schedule of Benefits*.

Routine Vision Exam

A routine vision exam of the eyes 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.

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.

SAMPLE

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. Such determination will be made by the Vision Care Provider and not by us.

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.

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:

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.

SAMPLE

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 *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 UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

UnitedHealthcare Vision Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under 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*.

SAMPLE

Section 13: 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 or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

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

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

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

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

Continuity of Care

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

Provider Directories

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

SAMPLE

Outline of Coverage

for Individual Exchange Medical Policy

UnitedHealthcare of Illinois, Inc.

200 West Madison, Suite 2600

Chicago, IL, 60606

Read Your Policy Carefully

This outline sets forth a brief description of the important aspects of your Policy. This is not the insurance contract. Only the actual Policy will control. The Policy sets forth in detail your and our rights and obligations.

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

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

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 found in the Policy.

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 of the Policy.

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.

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

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.

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends.
- **You Are No Longer Eligible**
- **We Receive Notice to End Coverage.**

Covered Health Care Services

Abortion Care Services

Benefits for Abortion Care Services, including both elective and therapeutic, procedural Abortion Care Services.

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 as described in the Policy.

SAMPLE

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial as described in the Policy.

Dental Anesthesia

Benefits will include general anesthesia and services incurred at a Hospital or ambulatory surgical center for any Medically Necessary dental procedure when provided to a Covered Person as described in the Policy.

Dental Services - Accident Only

Dental services when all of the following are true:

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

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

Diabetes Services

Diabetes Self-Management and Training and Education Services, and self-Management items as described in the Policy.

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. Examples of included items as described in the Policy.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency, including examination and treatment for sexual assault. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas as described in the Policy. Benefits are also provided for human breast milk when conditions are met as described in the Policy.

Fertility Preservation for Iatrogenic Infertility

Certain Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician. Covered medical and behavioral health services may not be denied solely because the diagnosis is gender dysphoria.

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

SAMPLE

Habilitative Services

For purposes of the 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. Habilitative Services are limited to physical therapy, occupational therapy, speech therapy, post-cochlear implant aural therapy, cognitive therapy and treatment for Autism Spectrum Disorders. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition, including children with congenital, genetic, or early acquired disorders, are not considered habilitative services.

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 as described in the Policy.

Home Health Care

Services received from a Home Health Agency, including Private Duty Nursing, as described in the Policy.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill as described in the Policy.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital as described in the Policy.

Infertility

Benefits are provided when rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer. Benefits are available as described in the Policy.

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 as described in the Policy.

Major Diagnostic and Imaging - Outpatient

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

Manipulative Treatment

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services. Naprapathic services are covered when rendered by a Naprapath as described in the Policy.

Mental Health Care and Substance-Related and Addictive Disorders Services

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 properly qualified behavioral health provider.

Mobile Integrated Health Care Services

Benefits include services to an eligible recipient for Medically Necessary Mobile Integrated Health Care Services.

Services include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures as approved by the applicable EMS Medical Director.

SAMPLE

Morbid Obesity Surgery

The plan covers 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 as described in the Policy. Ostomy supplies and urinary catheters are also covered.

Neuromuscular, Neurological, or Cognitive Impairment Treatment

Benefits include services for therapy, diagnostic testing, and equipment necessary to increase the quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Oral Surgery

Benefits include:

- Surgical removal of complete bony impacted teeth.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts.
- Associated anesthesia services.

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

Outpatient Prescription Drugs

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.

Pediatric Dental Care Services

Benefits for Covered Dental Care Services, as described in the Policy, for Covered Persons under the age of 19.

Pediatric Vision Care Services

Benefits for Covered Vision Care Services, as described in the Policy, for Covered Persons under the age of 19.

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.

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.

SAMPLE

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.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications, and postpartum home care following a vaginal delivery, as described in the Policy. Benefits are available if you are experiencing a mental, emotional, nervous, or substance use disorder or condition related to Pregnancy or postpartum complications. Benefits for these services are described under *Mental Health Care and Substance Use Disorders Services*. Benefits for Pregnancy, postpartum, and newborn care rendered from perinatal doulas or licensed certified professional midwives include services for home births, home visits, and support during labor, abortion, or miscarriage. Benefits for the necessary equipment and medical supplies for a home birth are provided under the applicable Benefit category in this *Policy.* Benefits also include two at-home, urine-based pregnancy tests that are prescribed to the Covered Person, regardless of whether the tests are otherwise available over-the-counter.

Preventive Care Services

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

Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis and mastectomy bras.
- Wig or hair prosthesis for Covered Persons with hair loss caused by alopecia, Chemotherapy, or radiation treatment for cancer or other conditions.

Please see the Policy for additional information.

Reconstructive Procedures

Reconstructive procedures when the primary purpose is for treatment of a medical conditions or improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenial Anomaly.

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

Benefits are available for inpatient and outpatient care for treatment of the of the birth defect known as cleft lip and cleft palate or both.

Please see the Policy for additional information on Reconstructive Procedures.

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 and hippotherapy.

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*.

SAMPLE

Please see the Policy for additional information.

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.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Benefits include surgical scopic procedures, tissue and cornea transplants, cataract surgery with a standard intraocular lens, bone-anchored hearing aids and oral surgery as described in the Policy.

Telehealth

Benefits are provided for services delivered via Telehealth/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 the Policy unless otherwise specified in the Schedule of Benefits of the Policy.

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 or pathology as described in the Policy.

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office as described in the Policy.

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 as described in the Policy. Transportation and lodging benefits are available as described in the Policy.

Urgent Care Center Services

Covered Health Care Services received at a Network or out-of-Network Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office as described in the Policy.

Virtual Care Services

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

Exclusions and Limitations

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 the *Policy*.

SAMPLE

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in the Policy, those limits are stated in the corresponding Covered Health Care Service category in the Schedule of Benefits of the Policy. 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 of the Policy. Please review all limits carefully in your Policy, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Alternative Treatments

Acupressure and acupuncture.

Aromatherapy.

Hypnotism.

Massage therapy.

Rolfing.

Other forms of alternative treatment.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services, transplant preparation, cancer treatment, or cleft palate.

Endodontics, periodontal surgery and restorative treatment, dental braces dental implants, bone grafts and other implant related procedures, and treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly are all excluded.

Exclusions herein do not apply to Benefits covered in the Policy under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

Devices, Appliances and Prosthetics

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

Orthotic appliances that straighten or re-shape a body part.

Cranial molding helmets and cranial banding except when used to avoid the need for surgery and/or facilitate a successful surgical outcome.

The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; or ultrasonic nebulizers.

Transport chairs including powered walker including enhancement accessories and combination wheeled

walker with seat and transport chair.

Devices and computers to help in communication and speech.

Oral appliances for snoring.

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

Diagnostic or monitoring equipment purchased for home use.

Powered and non-powered exoskeleton devices.

Powered Wheelchairs.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. See *Section 10: Outpatient Prescription Drugs* for prescription drug products covered under the pharmacy benefit.

Self-administered or self-infused medications.

SAMPLE

Non-injectable medications given in a Physician's office.

Over-the-counter drugs and treatments.

Growth hormone therapy.

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.

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.

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.

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.

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.

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

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

Experimental or Investigational or Unproven 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 an Experimental or Investigational Service in the treatment of that particular condition.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in the Policy. Hygienic and preventive maintenance foot care, treatment of flat feet, subluxation of the foot, shoes, shoe orthotics, shoe inserts and arch supports are all excluded.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies, as described in the Policy.

Nutrition

Food of any kind, infant formula, and standard milk-based formula. 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.* Nutritional or dietary supplements, except as required by law and services for dietary therapy. Please see the Policy for additional information on exclusions for nutritional therapy, food, and supplementation.

Personal Care, Comfort or Convenience

Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include: television; telephone; beauty/barber services. See the Policy for further examples.

Physical Appearance

Cosmetic Procedures, except for correction of Congenital Anomaly, as described under Reconstructive Services in *Section 1: Covered Health Care Services* of the Policy, treatments and programs. Examples include membership costs and fees for health clubs and gyms; scar or tattoo removal; liposuction (This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*) and weight loss programs. Please see the Policy for further examples.

SAMPLE

Procedures and Treatments

Medical and surgical treatments that are not considered Medically Necessary. Examples include removal of hanging skin, treatment of excessive sweating (hyperhidrosis), and biofeedback. Please see the Policy for further examples.

Providers

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

Services performed by a provider with your same legal address.

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

Infertility treatment-related services:

- Donor services, except those described under Infertility Services in *Section 1: Covered Health Care Services*.
- Gestational Carrier or Surrogate health care services, Gestational or Surrogate fees, and costs related to reproductive techniques.
- Non-medical Costs of donor eggs and donor sperm.
- The reversal of voluntary sterilization.
- In vitro fertilization regardless of the reason for treatment.
- Costs to treat erectile dysfunction and/or impotency.

Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). This exclusion does not apply to therapeutic abortion recommended by a doctor and performed when the mother's life or health is endangered.

Elective fertility preservation.

Please see the Policy for additional information.

Services Provided Under Another Plan

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.

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.

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.

Health care services during active military duty

Transplants

Health care services for organ and tissue transplants, except those described in the Policy. Please see the Policy for additional information.

Travel

Health care services provided in a foreign country.

SAMPLE

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us.

Types of Care, Supportive Services, and Housing

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long-term pain.

Custodial Care or maintenance care.

Domiciliary care.

Private Duty Nursing and one-on-one Private Duty Nursing, except as described under *Home Health Care*.

Respite care. This exclusion does not apply to respite care for which Benefits are provided as described in the Policy.

Rest cures.

Services of personal care aides.

Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Services in a Long-term Acute Care Facility (LTAC).

Independent living services.

Assisted living services.

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*.

Vision and Hearing

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).

Routine vision exams, including refractive exams to determine the need for vision correction.

Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).Eye exercise or vision therapy.

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.

All Other Exclusions

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 as described in the Policy.

Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy as described in the Policy.

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.

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

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

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.

Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.

Long term storage services.

SAMPLE

Autopsy.

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

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.

Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).

Blood or tissue typing for paternity testing are not a covered service.

Specimen Provenance testing are not a covered service.

Services or supplies for teaching, vocational, or self-training purposes, except as listed in the benefit plan.

Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.

Stand-by availability of a medical practitioner when no treatment is rendered.

Services or supplies that are provided prior to the effective date or after the termination date of the Policy.

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**.

SAMPLE

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.

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NOTICE OF PROTECTION PROVIDED BY ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not

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rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

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