Navigate Individual Medical Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

[Policy Number - [999-999-999]

[Policyholder - [John Doe]

[Effective Date - [Month, Day, Year]

[Expiration Date - [Month, Day, Year]

[Issue Date - [Month, Day, Year]

[Total Premium - [$XXXX.XX]

[Premium Mode - [Monthly][Quarterly]

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*.

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 Insurance Company



Robert Hunter, President

SAMPLE

What Is the Policy?

This *Policy* is a legal document between UnitedHealthcare Insurance Company 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*.
- Riders, including the *Outpatient Prescription Drug Rider*, the *Pediatric Dental Services Rider,* and the *Pediatric Vision Care Services Rider*.
- Amendments.

If you have any questions or requests about your plan, you can contact us by calling the telephone number on the back of your ID card or by calling us at 877-760-3322.

Can This Policy Change?

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

Other Information You Should Have

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

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

The Policy will take effect on the date shown in the *Policy*. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Policyholder's location. This *Policy* will remain in effect as long as the Premium is paid when they are due, subject to the renewal and termination provisions of this *Policy*.

We are delivering this *Policy* in Massachusetts. This *Policy* is subject to the laws of the state of Massachusetts. To the extent the law applies, Massachusetts law governs the Policy.

myHealthcare Cost Estimator

UnitedHealthcare is obligated to make healthcare more accessible and its costs more transparent, so you can make more informed healthcare decisions. myHealthcare Cost Estimator is an online tool designed to assist you in making informed decisions regarding treatment options, providers, and service locations. Cost estimates are displayed for Network Hospitals, Facilities and Physicians. Estimates are personalized to reflect an individual's own health plan benefits, including their real-time deductible and account balances when applicable.

myHealthcare Cost Estimator is available to UnitedHealthcare members at no additional cost. When you are able to get information based on your individual plan, you'll have the knowledge to better understand your choices and be in greater control of your health care.

Visit www.myuhc.com to get started with myHealthcare Cost Estimator or you can contact us by calling 877-760-3322.

Pre-Existing Conditions

Your coverage in this health plan is not limited based on medical conditions that are present on or before your effective date. This means that your health care services will be covered from the effective date of your coverage in this health plan without a pre-existing condition restriction or a waiting period. But, benefits for these health care services are subject to all the provisions of this health plan.

SAMPLE

Introduction to Your Policy

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

Interpreters

UnitedHealthcare provides members, upon request, interpreter and translation services related to administrative procedures. These services are generally provided through the AT&T language service.

español (Spanish)

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.
Si no es miembro de UHC, llame al 888-383-9253.

português (Portuguese)

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.
Caso não seja membro da UHC, ligue para 888-383-9253.

中文 (Chinese)

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。
如果您不是 UHC 會員，請撥打 888-383-9253。

Kreyòl ayisyen (Haitian Creole)

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.
Si ou pa manm UHC, rele 888-383-9253.

Việt (Vietnamese)

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.
Nếu quý vị không phải là hội viên của UHC, xin vui lòng gọi 888-383-9253.

русском (Russian)

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте. Если вы не являетесь участником UHC, вы можете позвонить по номеру 888-383-9253.

(Arabic) العربية

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.
إذا لم تكن عضوًا في UHC، اتصل على الرقم 888-383-9253.

ភាសាខ្មែរ (Khmer)

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។
បើសិនអ្នកមិនមែនជាសមាជិក UHC ទេ ទូរស័ព្ទទៅលេខ 888-383-9253។

français (French)

SAMPLE

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification. Si vous n'êtes pas affilié(e) à UHC, veuillez appeler le 888-383-9253.

l'italiano (Italian)

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa. Se non siete membri UHC, chiamate il numero 888-383-9253.

한국어 (Korean)

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.
UHC 회원이 아닌 경우, 888-383-9253 번으로 전화하십시오.

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.
Αν δεν είστε μέλος της UHC, καλέστε το 888-383-9253.

polsku (Polish)

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej. Jeżeli nie jesteś członkiem UHC, zadzwoń pod numer 888-383-9253.

हिंदी (Hindi)

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।. अगर आप UHC सदस्य नह ीं हैं, 888-383-9253 पर कॉल करें।

ગુજરાતી (Gujarati)

ધ્યાન આપો: જો તમે ગુજરાતી (**Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. કૃપા કરી તમારા આઇડેન્ટીફિકેશન કાર્ડ પર આપેલા ટોલ-ફ્રી નંબર પર કોલ કરો. જો તમે **UHC** ના સભ્ય ન હોવ તો 888-383-9253 પર કોલ કરો.

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 Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

How Do You Use This Document?

Read your entire *Policy* and any attached Riders and/or 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.

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.

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

If you are looking for more specific information about your Physician, the *Massachusetts Board of Registration in Medicine* may have a profile. To see this profile, you can log on to www.massmedboard.org.

How Do You Contact Us?

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

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Your Responsibilities

Enrollment and Required Premiums

- Benefits are available to you once 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 rules of this *Policy*, including the eligibility rules.
  - 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.

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

Pay Your Share

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

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.

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File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract.

SAMPLE

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part)

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for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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. We will cover the out-of-Network Covered Health Care Service and you will not be responsible to pay more than the amount which would be required for a similar Covered Health Care Service offered within our Network.

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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Individual Medical Policy

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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 rules as determined by the Massachusetts Health Connector.
- 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*.

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 this section unless otherwise specified in the *Schedule of Benefits*.

Benefits are provided for nutritional counseling services provided by an appropriate licensed or registered health care professional for the treatment of medical or mental health conditions. Benefits for the services are provided under the applicable Benefit category in this section. Nutritional counseling services for preventive care are described under *Preventive Care Services*.

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

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

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

1. Ambulance Services

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

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

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

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

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

2. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies

Cellular Therapy, Gene Therapy, and other genetic/molecular therapies received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility, a Physician's office, or in your home. These therapies must be provided by a Designated Provider.

Please refer to *Pharmaceutical Products - Outpatient* in this *Policy* for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies that do not need to be provided by a Designated Provider.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies.

3. Clinical Trials

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

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when 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

SAMPLE

- 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.

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.

SAMPLE

- 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*.

4. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

5. Dental Services - Anesthesia and Facility Charges

[General anesthesia and associated facility charges for dental services rendered in a Hospital or Alternate Facility when treatment cannot be completed in an office-based place of service due to the complexity of the treatment and/or the Covered Person's medical conditions. Benefits are only available if you are one of the following:

- A Covered Person 9 years of age or under who is receiving the services.
- A Covered Person of any age receiving the services who has behavioral disorders, physical disabilities, developmental disabilities, or other medical conditions that may necessitate dental treatment outside an office-based place of service.
- A Covered Person of any age receiving complex dental services necessitating treatment outside of an office-based place of service.

6. Diabetes Services

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

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

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

Laboratory tests, including hemoglobin, or HbA1c, tests and urinary protein/microalbumin and lipid profiles are described under *Lab, X-Ray and Diagnostics - Outpatient*.

Diabetic Self-Management Items

- Insulin pumps and supplies and integrated continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. For purposes of this Benefit, an "integrated continuous glucose monitor" is one that requires an insulin pump to function. An insulin pump is subject

SAMPLE

to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*

- Visual magnifying aids for use by the legally blind. Voice-synthesizers for blood glucose monitors for use by the legally blind.
- Therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician, the shoes or shoe inserts have been prescribed by a podiatrist or Physician, and the shoes or shoe inserts are furnished by a podiatrist, orthotist, prosthetist or pedorthist.
- Benefits for blood glucose meters including stand-alone continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices, insulin and insulin pens are described under the *Outpatient Prescription Drug Rider.*

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

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

Additionally, benefits are provided for DME when Medically Necessary and provided in conjunction with a Physician-approved eligible home health care services plan as described under *Home Health Care*.

DME and Supplies

Examples of DME and supplies include:

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

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

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

Orthotics

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

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

SAMPLE

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

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

8. Emergency Health Care Services - Outpatient

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

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

In an Emergency, you have the option to call 911 (or the local equivalent). You will not be denied coverage for medical and transportation services incurred when Emergency Health Care Services are provided as a result of accessing services by dialing 911. Benefits are paid for Emergency Health Care Services, even if the services are provided by an out-of-Network provider.

9. Enteral Nutrition

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

Donor Human Breast Milk and Milk-Derived Products

Benefits include pasteurized donor human milk and donor human milk-derived products when all of the following conditions are met.

- The milk is obtained from a human milk bank that meets quality guidelines established by the Department of Public Health.
- A licensed Physician has issued a written order for the provision of the human breast milk or donor human milk-derived products for the infant Covered Person; and
- The Covered Person is:
  - Under the age of 6 months;
  - Undergoing treatment in an inpatient setting for a congenital or acquired condition that places the infant at high risk for development of necrotizing enterocolitis or a congenital or acquired condition that may benefit from the use of human breast milk as determined by the Department of Public Health; and
  - Medically or physically unable to receive maternal breast milk or participate in breastfeeding or whose mother is medically or physically unable, despite receiving lactation support, to produce maternal breast milk in sufficient quantities or caloric density.

10. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause infertility. These medical reasons include, but are not limited to, cancer, 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.
- Storage and cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

SAMPLE

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

Benefits are not available for elective fertility preservation.

11. Gender Dysphoria

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

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

12. Habilitative Services

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

Habilitative services are limited to:

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

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

  - Licensed speech-language pathologist.
  - 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:

SAMPLE

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

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

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

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

13. 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 provided for all services related to a covered Hring Aid device every 36 months per hearing impaired ear through a licensed audiologist, Hearing Aid dispenser, otolaryngologist, or other authorized Provider. Benefits are provided for the Hearing Aid and associated fitting and adjustment charges, supplies (including earmolds) and testing.

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *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.

14. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Physical, occupational and speech therapy.
- Medical social work.
- Nutritional counseling.
- Home health aide services.
- Medical supplies.
- Durable Medical Equipment.

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

SAMPLE

15. 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.

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

16. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Voluntary termination of pregnancy (abortion).
- Sterilization procedure for a female Covered Person when performed as the primary procedure for family planning reasons.
- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a Physician other than the attending Physician; or by a certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a Physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.

17. Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART), including:
  - In vitro fertilization (IVF).
  - Gamete intrafallopian transfer (GIFT).
  - Zygote intrafallopian transfer (ZIFT).
- Intracytoplasmic Sperm Injection (ISCI) for the treatment of male factor infertility.
- Assisted hatching.
- Cryopreservation of eggs.
- Embryo Transfer.
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not payable by the donor's insurer.
- All other non-experimental infertility procedures.

To be eligible for Benefits, you must meet all of the following:

SAMPLE

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
    - One year, if you are a female under age 35.
    - Six months, if you are a female age 35 or older.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of the Benefit, “therapeutic donor insemination” means insemination with a donor sperm sample for the purpose of conceiving a child.

18. Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Diagnostic and supplemental breast screenings including screening mammograms, digital breast tomosynthesis and breast ultrasound.
- Cervical cancer screening - an annual cytologic screening for women 18 years of age and older.
- Laboratory tests for the treatment of diabetes, including hemoglobin, or HbA1c, tests and urinary protein/microalbumin and lipid profiles.

Benefits include:

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

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

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

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

19. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

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

20. Mental Health Care and Substance-Related and Addictive Disorders 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

SAMPLE

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, at a mental health clinic licensed by the *Massachusetts Department of Public Health*, at a public community mental health center or as a home-based service, to treat:

- Biologically-based mental disorders. For the purposes of this Benefit, "biologically-based mental disorders" includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, and Substance Use Disorder Treatment, including alcoholism." Benefits related to Autism Spectrum Disorders are provided under *Autism Spectrum Disorder Services* below.
- Rape-related mental or emotional disorders for victims of rape or assault with intent to commit rape.
- Non-biologically-based Mental Illness of Dependent children under 19 years of age when the Primary Care Provider, pediatrician, or licensed mental health professional treating the child has documented that the Mental Illness substantially interferes with or substantially limits the functioning and social interactions of the child or is evidenced by conduct including, but not limited to:
  - An inability to attend school as a result of the disorder.
  - The need to hospitalize the child as a result of the disorder.
  - A pattern of conduct or behavior caused by the disorder which poses a serious danger to the child or others.
  - Benefits for Mental Health Care Services that would otherwise terminate due to a Dependent child having reached 19 years of age may be continued for an Enrolled Dependent child who is engaged in an ongoing course of treatment beyond age 19 until that course of treatment is completed.
- Any other Mental Illness or mental health disorder not described above.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum 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 Disorders.
  - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.

SAMPLE

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

For children and adolescents under the age of 19: The services listed above include, but are not limited to: In-Home Behavioral Services (including behavior management monitoring and behavior management therapy), In-Home Therapy (including ongoing therapeutic training and support and therapeutic clinical intervention), Family Support and Training, Therapeutic Mentoring Services, Mobile Crisis Intervention, Intensive Care Coordination, Community-Based Acute Treatment for Children and Adolescents and Intensive Community-Based Treatment for Children and Adolescents.

Please note that (1) authorization is not required for covered Substance Use Disorder Treatment including Acute Treatment Services and Clinical Stabilization Services for a total of up to 14 days and (2) prior authorization is not required for Substance Use Disorder Treatment if the provider is certified or licensed by the *Department of Public Health* and (3) this also includes early intervention services for Substance Use Disorder Treatment, outpatient services, including medically assisted therapies; intensive outpatient and partial hospitalization services, residential or inpatient services, and medically managed intensive inpatient services.

Benefits include recovery coach services to provide guidance, support, and accountability to individuals seeking to overcome substance abuse or behavioral addictions.

21. Obesity - Weight Loss Surgery

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

22. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

23. Pharmaceutical Products - Outpatient

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

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

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Policy*. Benefits for medication normally available by a prescription order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

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

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

SAMPLE

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product(s) and/or prescription drug product(s) for which Benefits are provided as described under the *Outpatient Prescription Drug Rider* first.

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

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

For Cellular Therapy, Gene Therapy, and other genetic/molecular therapies that are provided by a Designated Provider, please refer to *Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies* as described in this *Policy*.

24. Physician Fees for Surgical and Medical Services

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

25. Physician's Office Services - Sickness and Injury

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

Covered Health Care Services include 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.
- Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS), including, but not limited to, the use of intravenous immunoglobulin therapy. Benefits for intravenous immunoglobulin therapy are described under *Pharmaceutical Products - Outpatient*.
- Benefits include allergy injections and allergy testing. (This includes tests that you need such as PRIST, RAST, and scratch tests.)

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

Benefits for pain management methods other than opiate treatment are available to you to manage pain linked to a physical cause. There are at least two (2) alternative medication treatment options covered under the Outpatient Prescription Drug Rider, and at least three (3) non-medication treatment modalities such as supplies, services or treatments that are appropriate as ordered by or provided by a Physician for pain management on an outpatient basis. Examples of non-medication treatment modalities include: manipulative treatment, non-manipulative osteopathic care, physical therapy and occupational therapy as described under *Section 1: Covered Health Care Services.*

26. Pregnancy - Maternity Services

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

Benefits also include screening for postpartum depression and major depressive disorder.

SAMPLE

Additionally, Benefits are provided for postpartum home visiting services when Medically Necessary and provided by qualified health professionals with requisite training as defined by the *Department of Public Health.*

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.

Childbirth classes. We will reimburse you up to $90 for one childbirth course for each covered expectant mother and up to $45 for each refresher childbirth course. Upon completion of the class, you must submit a copy of the policy of completion with dates attended, as well as a copy of the canceled check or receipt.

To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to us at:

UnitedHealthcare

PO Box 740800

Atlanta, GA 30374-0800

For a claim form or help to file a claim, you can contact us at the telephone number shown on your ID card. You will not be reimbursed for this amount unless you complete the course, except when your delivery occurs before the course ends.

Benefits include doula services.

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 discharge occurs earlier than these minimum time frames, Benefits include, but are not to be limited to, at least one home care visit, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. The first home visit must be conducted by a registered nurse, Physician, or certified nurse midwife; and any subsequent home visit determined to be clinically necessary be provided by a licensed health care provider.

Please note: for the purposes of this section attending Physician includes attending obstetrician, pediatrician or certified nurse midwife attending the mother and newly born child.

Benefits are available for the following screening tests when provided to the newborn child prior to discharge from the Hospital:

- A hearing screening test to detect hearing thresholds of 30 decibels or greater in the speech frequency range in either ear.
- Hereditary and metabolic screening at birth.
- Routine circumcision that is furnished by a Physician.

27. Preimplantation Genetic Testing (PGT) and Related Services

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

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:

SAMPLE

- Ovulation induction (or controlled ovarian stimulation).
- Egg retrieval, fertilization and embryo culture.
- Embryo biopsy.
- Embryo transfer.
- Cryo-preservation and short-term embryo storage (less than one year).

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

28. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* (www.uspreventiveservicestaskforce.org), including:
  - Screening colonoscopy or sigmoidoscopy.
  - Tobacco use cessation counseling.
- Annual Mental Health Wellness Examination performed by a Licensed Mental Health Professional or a Primary Care Provider, which may be provided by the Primary Care Provider as part of the annual preventive visit. Please note that there may be follow-up services necessary.
- Immunizations for: (i) routine childhood immunizations for residents of the commonwealth; and (ii) immunizations for residents of the commonwealth who are 19 years of age and older that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention* (CDC)(www.cdc.gov).
- 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* (HRSA)(www.hrsa.gov), including screening for lead poisoning. For purposes of this Benefit, "preventive care services" means Physician's office services rendered to an Enrolled Dependent child from the date of birth through the attainment of six years of age, including physical exam, history, measurements, sensory screening, neuropsychiatric evaluation and development screening assessments at the following intervals: six times during the child's first year after birth; three times during the next year; and annually thereafter until age six.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* (HRSA) (www.hrsa.gov).
  - Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include:
    - Lactation counseling and education services to ensure the successful initiation and maintenance of breastfeeding. Contact us at www.myuhc.com or the telephone number on your ID card, or ask your Primary Care Provider, if you have any questions or need assistance locating a provider for these services.
    - One breast pump per Pregnancy in conjunction with childbirth, including 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.

SAMPLE

An exception process may apply to certain categories of preventive care services if your health care provider determines that an alternative preventive care service is Medically Necessary for you.

An expedited exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health.

To request an exception your health care provider must fill out the exception request form with the appropriate clinical information and attest that the requested preventive care service is Medically Necessary for you.

If a request for an exception is approved by us, Benefits provided for the health care service will be treated the same as a preventive care service Benefit.

For more information and to access the exception request form, please visit www.uhcprovider.com then go to *Resource Library and Provider Forms (Commercial Plans)*. For questions, call the telephone number shown on your ID card.

- Fitness Benefit. We will reimburse you for your costs for monthly membership fees for three consecutive months of one family or individual health club membership at a qualified health club during a calendar year. You can claim this fitness benefit once each calendar year. This fitness benefit applies for fees paid to: qualified health clubs which must include both cardiovascular (i.e. treadmills, bikes, elliptical machines) and strength training (i.e. free weights, weight machines) exercise equipment. Examples of qualified health clubs include (but are not limited to): YMCA, YWCA, LA Fitness, Bally's, Life Time Fitness, Boost Fitness, Best Fitness and community Fitness Centers. Please note that non-qualified health club memberships are not eligible for reimbursement.
- Weight Loss Program Benefit. We will reimburse you for your costs for up to three months for participation in qualified weight loss program(s) each calendar year. A qualified weight loss program is a hospital-based weight loss program or a non-hospital-based weight loss program designated by us. You can claim this one-twelve-month weight loss program benefit once each calendaryear for any combination of members (such as the subscriber, spouse, and/or dependent children). Examples of qualified weight loss programs include (but are not limited to): The Weight Watchers Traditional, Weight Watchers at Work programs, Weight Watchers Online and hospital-based weight loss programs offered by and held at licensed hospitals qualify for reimbursement.
    - To receive your fitness program and/or weight loss program benefit, you must file a claim. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to us at:

      UnitedHealthcare

      PO Box 740800

      Atlanta, GA 30374-0800
    - For a claim form or help to file a claim, you can call us at the telephone number shown on your ID card.

29. Prosthetic Devices

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

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

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

SAMPLE

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

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

Augmentative communication devices. An “augmentative communication device” is one that assists in restoring speech. It is needed when a member is unable to communicate due to an accident, Illness, or disease such as amyotrophic lateral sclerosis (ALS).

30. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. This includes the necessary care and treatment of medically diagnosed Congenital Anomalies in newly born and adoptive children enrolled under the Policy. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

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

31. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

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

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

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

SAMPLE

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

Benefits are not available for maintenance/preventive treatment.

32. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

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

33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

34. Surgery - Outpatient

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

SAMPLE

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

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.
- Routine circumcision.
- Voluntary termination of pregnancy (abortion).
- Sterilization procedure for a female member when performed as the primary procedure for family planning reasons.
- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a Physician other than the attending Physician; or by a certified registered nurse anesthetist.

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

Benefits include:

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

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

35. Temporomandibular Joint (TMJ) Services

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

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

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints), including splint therapy. (This also includes measuring, fabricating, and adjusting the splint.)
- Arthrocentesis.
- Trigger-point injections.

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

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

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

SAMPLE

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

36. Therapeutic Treatments - Outpatient

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

- Dialysis (both hemodialysis and peritoneal dialysis) furnished for you by a Hospital; or by a community health center; or by a free-standing dialysis facility; or by a Physician. This coverage also includes home dialysis when it is furnished under the direction of a covered provider. Your home dialysis coverage includes: non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home; and the cost to maintain or to fix the dialysis equipment.
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.
- Radiation and x-ray therapy that is furnished for you by a Physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Drug therapy for cancer (chemotherapy).

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*.

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

37. Transplantation Services

Organ and tissue 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, including CAR-T cell therapy for malignancies and bone marrow transplants for Covered Persons with breast cancer that has progressed to metastatic disease.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

SAMPLE

Benefits are available for human leukocyte antigen testing or histocompatibility locus antigen testing, including testing for A, B, or DR antigens or any combination thereof, necessary to establish bone marrow transplant donor suitability.

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

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

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

38. Urgent Care Center Services

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

39. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

40. Virtual Care Services

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

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

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

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

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

Additional Benefits Required By Massachusetts Law

41. Abortion and Abortion-Related Services

Benefits include Covered Health Care Services for abortion and abortion-related services. Coverage for an abortion includes: surgical services and certain prescription drugs related to a medication abortion such as mifepristone and misoprostol; and abortion-related care as defined by the Massachusetts Division of Insurance guidance. Covered health care services for abortion-related care includes (but are not limited to) including pre-abortion and follow-up services.

SAMPLE

42. Autism Spectrum Disorder Treatment

Benefits are provided for therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist for the treatment of Autism Spectrum Disorders.

Coverage is not provided for services related to Autism Spectrum Disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

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

Autism services provider - a person, entity or group that provides treatment of Autism Spectrum Disorders;

Autism spectrum disorders - any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified;

Board certified behavior analyst - a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst;

Habilitative or rehabilitative care - professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual;

Pharmacy care - medications prescribed by a licensed Physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the contract for other medical conditions;

Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

Psychological care - direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices; and

Therapeutic care - services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Diagnosis of autism spectrum disorders: Medically Necessary assessments, evaluations including neuropsychological evaluations, Genetic Testing or other tests to diagnose whether an individual has 1 of the autism spectrum disorders.

Treatment of autism spectrum disorders: includes the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed Physician or a licensed psychologist who determines the care to be Medically Necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

43. COVID-19 Testing and Treatment

Services to diagnose or treat the 2019 novel coronavirus disease (COVID-19) when the services are furnished by a Network or an out-of-Network provider. This coverage includes inpatient or outpatient services such as:

- Emergency Health Care Services and Ambulance Services.
- Hospital or other covered health care facility services.
- Cognitive rehabilitation therapy.
- Professional, diagnostic and laboratory services.

SAMPLE

- Medically necessary COVID-19 testing, including testing for asymptomatic members according to guidelines set by the Commonwealth of Massachusetts Secretary of the Executive Office of Health and Human Services.

These Covered Health Care Services also include covered drugs and supplies that are furnished by a Network pharmacy when your outpatient prescription drug benefit is provided under this plan.

If a benefit limit would normally apply to any of the Covered Health Care Services listed above, a benefit limit will not apply for Covered Health Care Services to diagnose or treat COVID-19.

Benefits as described under *COVID-19 Testing and Treatment* in *Section 1: Covered Health Care Services* will continue until directed by the Massachusetts Division of Insurance.

44. Down Syndrome Services

Benefits are provided for therapy and applied behavior analysis services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or behavior analysis for the treatment of Down syndrome.

Coverage is not provided for services related to Down syndrome provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

For purposes of this Benefit, the following definitions apply:

Applied behavior analysis - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Down syndrome - a chromosomal condition caused by an error in cell division that results in the presence of an extra whole or partial copy of chromosome 21.

45. Early Intervention Services

Medically Necessary early intervention services provided to children younger than three years of age and delivered by certified early intervention specialists in accordance with applicable certification requirements and as defined in the early intervention operational standards established by the *Massachusetts Department of Public Health*. Such services must be provided by certified early intervention specialists who are working in early intervention programs approved by the *Massachusetts Department of Public Health*.

46. HIV-Associated Lipodystrophy Treatment

Coverage for medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome to the same extent as Benefits would be provided for the treatment of other conditions including, but not limited to, reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injections or fillers for reversal of facial lipoatrophy syndrome. A statement from a treating provider that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome is required.

47. Hormone Replacement Therapy and Contraceptive Services

Hormone replacement therapy services for peri- and post-menopausal women and outpatient contraceptive services. For purposes of this Benefit, "outpatient contraceptive services" means patient education and counseling, exams, procedures, management of side effects, counseling for continued adherence and device insertion and removal and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy that have been approved by the *Federal Food and Drug Administration (FDA).*This includes over-the-counter or dispensed FDA-approved emergency contraception. Benefits are not subject to deductibles, Co-payments and/or Co-insurance when provided in accordance with the comprehensive guidelines supported by Massachusetts law. Unless your Physician recommends a particular FDA-approved oral contraceptive, FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent may be subject to a cost-share. In the event of an appeal of an adverse determination

SAMPLE

of a request for coverage of an alternative FDA-approved contraceptive drug, device or other product without cost-sharing shall be subject to the expedited grievance process.

Benefits for contraceptive drugs and devices are described under the *Outpatient Prescription Drug Rider*.

48. Hypodermic Needles and Syringes

Medically necessary hypodermic syringes or hypodermic needles when prescribed by a Physician.

49. Opioid Antagonists

Opioid antagonist drugs used in the reversal of overdoses caused by opioids when dispensed by the health care facility in which the opioid antagonist was prescribed or ordered. Opioid antagonist drugs dispensed by a pharmacist are covered under the *Outpatient Prescription Drug Rider*.

50. Speech, Hearing, and Language Disorders

Outpatient rehabilitation services for the diagnosis and treatment of speech, hearing and language disorders performed by a Physician or by a licensed therapy provider, including a licensed speech-language pathologist or a licensed audiologist acting within the scope of his or her license. This includes routine hearing exams and tests furnished for you by a covered provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

51. Treatment of Cleft Lip or Palate or Both

Coverage of treatment of cleft lip or palate or both for children under the age of 18 for medical, dental, oral and facial surgery, surgical management, and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services. Services must be provided by or under the direction of a Physician or surgeon who certifies that the services are medically necessary and consequent to the treatment of the cleft lip or palate or both.

52. Wigs

Scalp hair prostheses (wigs). This coverage is provided only when hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus).

SAMPLE

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing, and
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*.

B. Dental

Except for those Benefits under the *Pediatric Dental Services Rider* of this *Policy*.

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

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

   - Transplant preparation.

SAMPLE

- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate as described under *Treatment of Cleft Lip or Palate or Both* in *Section 1: Covered Health Care Services*.

Facility and anesthesia charges are covered when you have a serious medical condition that requires that you be admitted to a Hospital as an inpatient or to a surgical day care unit of a Hospital or to an ambulatory surgical facility in order for your dental care to be safely performed.

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. This exclusion does not apply to the surgical removal of complete bony impacted 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). This exclusion does not apply to cleft lip/palate - related dental services for which Benefits are provided as described under *Treatment of Cleft Lip or Palate or Both* in *Section 1: Covered Health Care Services.*
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under *Treatment of Cleft Lip or Palate or Both* in *Section 1: Covered Health Care Services.*

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
   - 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 for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under

SAMPLE

Durable Medical Equipment (DME), Orthotics and Supplies in *Section 1: Covered Health Care Services.*

5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
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 when not prescribed by a health care provider.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

SAMPLE

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

E. Experimental or Investigational Services

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

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

F. Foot Care

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

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes. This exclusion does not apply to therapeutic/molded shoes inserts for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Shoe orthotics.
6. Shoe inserts. This exclusion does not apply to therapeutic/molded shoes inserts for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
7. Arch supports.

G. Medical Supplies and Equipment

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

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

SAMPLE

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

H. Nutrition

1. Nutritional counseling that is non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to nutritional counseling services as described under *Introduction* in *Section 1: Covered Health Care Services*, *When Are Benefits Available for Covered Health Care Services*?
2 Food of any kind, infant formula, and standard milk-based formula. This exclusion does not apply to enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

I. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.

SAMPLE

- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

J. Physical Appearance

1. Procedures or services that are not reconstructive.
   - 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.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
2. Cosmetic Procedures unless considered reconstructive as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

   For Cosmetic Procedures see the definition in *Section 8: Defined Terms*. Examples may include:
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
   - Abdominoplasty.
   - Blepharoplasty.
   - Body contouring.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.

SAMPLE

- Mastopexy.
- Pectoral implants.
- Rhinoplasty.
- Skin resurfacing.

This exclusion does not apply to Cosmetic Procedures for which Benefits are provided for Medically Necessary services for gender dysphoria as described under *Gender Dysphoria* in *Section 1: Covered Health Care Services.*

3. 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*.
4. Treatment of benign gynecomastia (abnormal breast enlargement in males).
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility. This exclusion does not apply to the Fitness Benefit as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.
6. Wigs regardless of the reason for the hair loss. This exclusion does not apply to scalp hair prosthesis for which Benefits are provided as described under *Wigs* in *Section 1: Covered Health Care Services*.

K. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. 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. 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. This exclusion does not apply to reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. You must have a serious medical condition that requires that you be admitted to a Hospital as an inpatient in order for the surgery to be safely performed.
8. Non-surgical treatment of obesity.
9. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
10. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.* This exclusion does not apply to breast reduction surgery for treatment of gender dysphoria.
11. Helicobacter pylori *(H. pylori)* serologic testing.

SAMPLE

12. Intracellular micronutrient testing.

13. Cellular Therapy, Gene Therapy, and other genetic/molecular therapies not received from a Designated Provider.

L. 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.

M. Reproduction

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

   - All costs related to reproductive techniques including:
     - Assisted reproductive technology (ART).
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
     - Preimplantation Genetic Testing (PGT) and related services.

     The exclusion for costs related to reproductive techniques does not apply to artificial insemination when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

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

2. Costs of donor eggs and donor sperm, except as described under *Infertility Services* in *Section 1: Covered Health Care Services*.

SAMPLE

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

N. Services Provided under another Plan

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

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

O. Transplants

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

P. Travel

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

Q. Types of Care, Supporting Services, and Housing

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

SAMPLE

2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Independent living services.
9. Assisted living services.
10. 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 *Individual with Disabilities Education Act*.
11. 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).
12. Transitional Living services (including recovery residences).

R. Unproven Services

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

S. Vision and Hearing

Except for those Benefits under the *Pediatric Vision Services Rider* of this *Policy*.

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).

   This exclusion does not apply eye glasses or (intraocular lenses that are implanted) after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced. We will cover the cost of one pair of eye glasses or (intraocular lenses that are implanted).
3. Eye exercise or vision therapy.
4. 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.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

SAMPLE

T. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *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*.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived, except as outlined under *COVID-19 Testing and Treatment* in *Section 1: Covered Health Care Services.* Benefits as described under *COVID-19 Testing and Treatment* in *Section 1: Covered Health Care Services* will continue until directed by the Massachusetts Division of Insurance.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease

SAMPLE

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*.
19. No fitness Benefit is provided for any health club initiation fees or fees or costs that you pay for: personal training sessions; country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.
20. No weight loss program Benefit is provided for any fees or costs that you pay for: online weight loss programs; any non-Hospital-based weight loss program not designated by use; individual nutrition counseling sessions; pre-packaged meals, books, videos, scales, or other items or supplies bought by the member; and any other items not included as part of a weight loss class or weight loss course.

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 Massachusetts Health Connector. Go to MAhealthconnector.org for information on open enrollment, eligibility rules and enrollment assistance. 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. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

Who Is Eligible for Coverage?

The Massachusetts Health Connector determines who is eligible to enroll under this *Policy* and who qualifies as a Dependent. Go to MAhealthconnector.org for information on open enrollment, eligibility rules and enrollment assistance.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Massachusetts Health Connector. 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 Massachusetts Health Connector.

This *Policy* is not a Medicare supplement policy. If you are eligible for Medicare, you should look at the Guide to Health Insurance for People with Medicare.

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 Massachusetts Health Connector. Go to MAhealthconnector.org for information on open enrollment, eligibility rules and enrollment assistance.

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Coverage begins on the date determined by the Massachusetts Health Connector 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 Massachusetts Health Connector. Go to MAhealthconnector.org for information on open enrollment, eligibility rules and enrollment assistance.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Massachusetts Health Connector. Go to MAhealthconnector.org for information on enrollment assistance.

The Policyholder must notify the Massachusetts Health Connector of a new Dependent to be added to this *Policy*. The effective date of the Dependent's coverage must follow the Massachusetts Health Connector rules. Additional Premium may also be required, and it will be calculated from the date determined by the Massachusetts Health Connector.

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.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

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 Massachusetts Health Connector of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Massachusetts Health Connector. 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.

SAMPLE

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),* we will pay for Covered Health Care Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. 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 initial 31-day 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.

SAMPLE

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

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

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

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

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this *Policy* ends. That date will be one of the following:

  - The date determined by the Massachusetts Health Connector 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 an Enrolled Dependent, as determined by the Massachusetts Health Connector. Please refer to *Section 8: Defined Terms* for definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

SAMPLE

- Your coverage ends on the date determined by the Massachusetts Health Connector rules if we receive notice from the Massachusetts Health Connector instructing us to end your coverage.
- Your coverage ends on the date determined by the Massachusetts Health Connector 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.

- **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.

- You Accept Reimbursement for Premium
- You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this *Policy*. This prohibition does not apply to 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.

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.

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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 Massachusetts Health Connector.

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Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

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:

Optum Rx

PO Box 650540

Dallas, TX 75265-0540

Payment of Claims

Time for Payment of Claim

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Benefits will be paid as soon as we receive all of the required information listed above.

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. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of such 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.

Any such payment to an out-of-Network provider:

- Is not an assignment of your Benefits under the *Policy* or of any legal or equitable right to institute any proceeding relating to your Benefits,
- Is not a waiver of the prohibition on assignment of Benefits under the *Policy*, and
- Will not preclude us from asserting that any purported assignment of Benefits under the *Policy* is invalid and prohibited.

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

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

SAMPLE

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

If someone other than yourself is submitting the complaint on your behalf, you must authorize the representative in writing.

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of the medical claim information needed. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or

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additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

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

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

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 provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

The Office of Patient Protection. The Office of Patient Protection of the Health Policy Commission is the agency responsible for enforcing the Massachusetts laws concerning grievance rights and for administering appeals to external review organizations. The Office of Patient Protection has developed regulations and implemented procedures concerning grievances, medical necessity guidelines, continuity of care and independent external review. You may obtain a report regarding the number of appeals and complaints filed with us and their outcome from the Office of Patient Protection.

The Office of Patient Protection can be reached at:

Health Policy Commission

Office of Patient Protection

Telephone: 1-800-436-7757

Fax: 1-617-624-5046

Web Site: https://masshpc.gov/opp

Enrollment Required for Coverage. To be eligible for coverage, you must be duly enrolled on the date a service is received. A response to an informal inquiry or an appeal decision approving coverage will not be valid for services received after the termination date. However, payment may be made after the termination date for services received while enrollment was effective.

SAMPLE

The Formal Complaint Procedure

Contact us at the telephone number shown on your ID card. Our representatives are available to take your call during regular business hours, Monday through Friday. If a complaint is filed by telephone, a representative will write a summary of the complaint and send it to you within 48 hours of receipt. This time limit may be extended by mutual agreement between you and us. Any such agreement must be in writing.

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

Written complaints will be acknowledged in writing within 15 calendar days of receipt. This time limit may be extended by written mutual agreement between you and us. No acknowledgment of a complaint will be sent if a representative has previously sent a summary of a complaint submitted by telephone.

If we need to review your medical records you agree to furnish us with required information as described in the Information and Records provision in *Section 7: General Legal Provisions*.

You will be provided with a written response to a complaint within 30 business days of the date the complaint was received. This time limit may be extended by mutual agreement between you and us. Any extension will not exceed 30 business days from the date of the agreement. Any such agreement must be in writing.

If a complaint requires the review of medical records, the date of receipt will be the date we receive all necessary information. If we do not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date we receive the informal inquiry. No complaint shall be deemed received until actual receipt of the complaint at the appropriate address or telephone number listed above.

If we do not act on a complaint concerning benefits under this contract within 30 business days, plus any extension of time mutually agreed upon in writing by you and us, the complaint will be deemed to be resolved your favor.

The Formal Appeal Process

How to File an Appeal

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

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

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

Documentation of Oral Appeals

If an appeal is filed by telephone, an Appeal Coordinator will write a summary of the appeal and send it to you within 48 hours of receipt. This time limit may be extended by written mutual agreement between you and us.

Acknowledgment of Appeals

Appeals will be acknowledged in writing within 15 calendar days of receipt. If your oral grievance was reduced to writing by us, your copy, of that grievance will be the acknowledgement. This acknowledgement period may be waived or extended if both you and we agree to a waiver or extension.

Release of Medical Records

SAMPLE

If we need to review your medical records you agree to furnish us with required information as described in the Information and Records provision in *Section 7: General Legal Provisions*.

Time Limit for Processing Appeals

You will be provided with a written or electronic notification of appeal decision within 30 business days of the date the appeal was received. These time limits may be extended by mutual agreement between you and us. Any extension will not exceed 30 business days from the date of the agreement. We may decline to extend the review period for an appeal if a service has been continued pending an appeal.

Any appeal which requires the review of medical records will include your signature or your authorized representatives' signature on a form provided by us authorizing the release of medical and treatment information to us, in a manner consistent with state and federal law. We will request the authorization from you when necessary for requests reduced to writing by us and for any written requests lacking the authorization.

The 30 business day time period for written resolution of a grievance, which does not require the review of medical records, begins:

On the day immediately following the 3 business day time period for processing inquiries, if the inquiry has not been addressed within that period of time; or

On the date you or your authorized representative, if any, notifies us that you are not satisfied with the response to an inquiry if earlier than the 3 business day period.

The time limits in this section may be waived or extended by your and our written mutual agreement.

If we do not properly act on any appeal within the required time limits, the grievance will be deemed resolved in your favor. The time limits include any mutually agreed upon extensions made between us and you or your authorized representative.

If a grievance is filed concerning ongoing Benefits, those Benefits will be provided through the completion of the grievance process. These Benefits do not include Benefits which were terminated because of a specific time or episode-related limit or exclusion under the Policy.

Continuation of Services Pending Appeal

If an appeal is filed concerning the termination or reduction of coverage for ongoing treatment, such coverage will be continued through the completion of the internal appeal process if:

- The service was authorized by us prior to a request for an informal inquiry or the filing of an appeal;
- The service was not terminated or reduced due to a benefit limit under this *Policy*; and
- The appellant is, and continues to be, a duly enrolled Eligible Person under this *Policy*.

The Expedited Appeal Process

Your grievance requires immediate action when your Physician judges that a delay in treatment would significantly increase the risk to your health.

You may obtain expedited review of certain types of appeals. An expedited appeal may be requested if we deny coverage for health care services involving:

- Continued hospital care,
- Care that a Physician certifies is required to prevent serious harm, or
- A Covered Person with a terminal illness.

An expedited appeal will not be granted to review a termination or reduction in coverage resulting from:

- A benefit limit or cost sharing provision of this *Policy*, or
- The termination of enrollment.

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If we do not act on an expedited appeal within the time limits stated below,

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including any extension of time mutually agreed upon in writing by you and us, the appeal will be deemed to be resolved in your favor. Our decision will be sent to you in writing.

If you are filing an expedited appeal with us, you may also file a request for expedited external review with the Massachusetts Office of Patient Protection at the same time. You do not have to wait until we complete your expedited appeal to file for expedited external review. The procedure for obtaining external review is summarized below under "*What If Your Appeal Is Denied*?"

Expedited Review of Appeals for Continued Hospital Care

If you are an inpatient in a hospital you will be provided with an expedited review of any action by us to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of the coverage for your hospital stay. Coverage for services will be continued through the completion of the appeals process. The Plan will provide you with written notification of the appeal decision prior to discharge from a hospital.

Expedited Review of Appeals for Durable Medical Equipment

An expedited review will be provided for appeals for services or Durable Medical Equipment that, if not immediately provided, could result in serious harm to you. “Serious harm” means circumstances that could jeopardize your life or health, jeopardize your ability to regain maximum function, or result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which we have denied coverage for a service or Durable Medical Equipment if the Physician recommending the treatment or Durable Medical Equipment provides us with a written certification stating that:

- The service or Durable Medical Equipment is Medically Necessary;
- A denial of coverage for the service or Durable Medical Equipment would create a substantial risk of serious harm to the you; and
- The risk of serious harm is so immediate that the provision of the service or Durable Medical Equipment should not await the outcome of the normal appeal process.

A decision may take place earlier than 48 hours for Durable Medical Equipment if a request for such early reversal is included in the certification, and the Physician’s certification includes specific facts indicating the immediate and severe harm that will result from a 48-hour delay.

Right to Request a Conference

If the expedited review process upholds the denial of coverage or treatment, you, or your authorized representative, may request a conference to review this information. The conference will be scheduled within 10 days of your request. The conference will be held within 5 business days of the request if the treating Physician determines, after consultation with our medical director or his designee, and based on standard medical practices, that the effectiveness of either the proposed treatment, services or supplies or any covered alternative treatment, services or supplies, would be materially reduced if not provided at the earliest possible date. You, your authorized representative, and/or your provider may attend the conference.

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If we do not act on an expedited appeal within the time limits stated below, including any extension of time mutually agreed upon in writing by you and us, the appeal will be deemed to be resolved in your favor. Our decision will be sent to you in writing.

What If Your Appeal Is Denied?

If you disagree with the decision of your appeal, you may have a number of options for further review. These options may include reconsideration of appeals that involve a medical necessity determination or external review by an independent organization appointed by the Office of Patient Protection. Below is a summary of these options.

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Reconsideration

If you are not satisfied with a decision concerning an appeal that involves a medical necessity determination you can ask that decision be reconsidered if relevant medical information:

- Was received too late to review within the 30 business day time limit; or
- Was not received but is expected to become available within a reasonable time period following the last decision.
- Reconsideration is not available for the following types of appeals:
  - Decisions involving a benefit limitation where the limit is stated in this *Policy* or any Riders or Amendments;
  - Decisions involving excluded services, except Experimental or Investigational Services or Unproven Services; and
  - Decisions concerning cost sharing requirements.
- When you or your authorized representative, if any, chooses to request reconsideration, we must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance.
- You also may request an external review as described below. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

External Review

If you wish to contest a final appeal decision involving a medical necessity determination you may request external review of the decision by an independent organization under contract with the Office of Patient Protection of the Health Policy Commission. You must file the request within 4 months of your receipt of the written notice of the final determination. You may request to have the external review processed as an expedited external review. In this case, the Physician must certify that delay of the health care services for which Benefits have been denied would pose a serious and immediate threat to your health. When a final determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility, a certification from a health care professional is not necessary to request an expedited external review.

You must pay a fee of $25 to the Office of Patient Protection which should be included with the request for a review. The fee may be waived by the Office of Patient Protection if they determine that the payment of the fee would result in an extreme financial hardship to the insured.

If the subject matter of the external review involves the termination of ongoing Benefits, you may apply to the external review panel to seek the continuation of Benefits for the terminated service during the period the review is pending. The review panel may order the continuation of Benefits where it determines that substantial harm to your health may result absent such continuation or for such other good cause as the review panel will determine. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency and notification will be provided to you (or your representative) and us. The decision of the external review agency is binding and must be complied with by us.

If the Office of Patient Protection determines that a request is not eligible for external review, you (or your representative) will be notified within 10 business days or, in the case of requests for expedited review, 72 hours.

The final decision of the review panel will be in writing and set forth the specific medical and scientific reason for the decision and will be furnished to you, or where applicable your authorized representative, and to us.

The Office of Patient Protection may be reached at:

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Health Policy Commission

Office of Patient Protection

50 Milk Street, 8th Floor

Boston, MA 02109

Telephone: 1-800-436-7757

Fax: 1-617-624-5046

Web Site: Office of Patient Protection | Massachusetts Health Policy Commission

What Are Your Rights Under Mental Health Parity Laws?

This plan is subject to state and federal Mental Health Parity laws, which generally prohibit insurance plans from providing mental health or substance use disorder benefits in a more restrictive manner than other medical benefits. If a health plan member believes UnitedHealthcare standards or practices relating to the provision of mental health or substance use disorder benefits are not compliant with applicable mental health parity laws, the health plan member or an authorized representative may submit a complaint to the Division of Insurance at:

Division of Insurance
1 Federal Street
Suite 700
Boston, MA 02110

Telephone: 1-877-563-4467
Fax: 1-617-753-6830
TTD/TDD: 1-617-521-7490

Complaints may be submitted verbally or in writing to the Division's Consumer Services Section for review. Insurance Complaint Forms can be found on the Division's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

Submitting a complaint to the Division does not impact your internal or external appeal rights under this plan.

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Section 7: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers?

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

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. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not responsible for any act or omission of any provider.

What Is Your Relationship with Providers?

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

You are responsible for all of the following:

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

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

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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, interpret, withdraw or add Benefits or end this *Policy*.

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

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

- Amendments and Riders to 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*.

We will provide to the Individual notice of all material changes to the Policy by issuing an Amendment, Rider, or a new Policy.

We will provide to the Individual prior notice of modification in Covered Health Care Services. This notice will be provided at least 60 days before the effective day of the modifications. The notice will include the following:

- Any changes in clinical review criteria.
- A statement about your share, if any, of the cost of the changes.

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

Subrogation Example:

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

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

Reimbursement Example:

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

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers’ compensation case or other matter alleging liability.

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

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right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We and all administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under 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 Riders and/or Amendments, make up the entire *Policy*.

Genetic Testing and Privacy Information

We are prohibited from canceling, refusing to issue or renew, or in any other way making or permitting any distinction or discrimination based on genetic information, the amount of payment of premium or rates charged, the length of coverage, or in any other of the terms and conditions of the Policy. In addition, neither us, nor any officers, agents or brokers may require genetic tests or genetic information, as defined below, as a condition of the issuance or renewal of any such coverage.

For purposes of this provision, "genetic information" is any written or recorded individually identifiable result of a genetic test as defined below or explanation of such a result. Genetic information will not include any information about an identifiable person that is taken as part of any of the following:

- A biopsy, autopsy, or clinical specimen solely for the purpose of conducting an immediate clinical or diagnostic test that is not a test of DNA, RNA, mitochondrial DNA, chromosomes or proteins.
- A blood sample solely for blood banking.

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- A newborn screening.
- Confidential research information for use in epidemiological and clinical research conducted for the purpose of generating scientific knowledge about genes or learning about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.
- Information pertaining to the abuse of drugs or alcohol which is derived from tests given for the exclusive purpose of determining the abuse of drugs or alcohol.

For purposes of this provision, "genetic test" is a test of human DNA, RNA, mitochondrial DNA, chromosomes or proteins for the purpose of identifying genes, inherited or acquires genetic abnormalities, or the presence or absence of inherited or acquired characteristics in genetic material. For the purposes of this provision, the term genetic test will not include tests given for drugs, alcohol, cholesterol, or HIV; or any test for the purpose of diagnosing or detecting an existing disease, illness, impairment or disorder.

Utilization Review Procedures

We use the following utilization review procedures described below to review Covered Health Care Services against clinical criteria to determine whether the health care service, supply or Pharmaceutical Product is Medically Necessary.

- Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. Pre-service utilization review determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice to the requesting provider by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within two working days thereafter. In the case of a determination to deny or reduce benefits ("an adverse determination"), we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.
- Concurrent utilization review is a review of authorized admissions to hospitals and extended care facilities, and skilled home health care services. Concurrent review decisions will be made within one working day of obtaining all necessary information. The service will be continued without liability to you until you have been notified of the determination. In the case of a determination to approve an extended stay or additional services, we will notify the provider rendering the service by telephone within one working day of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter. In the case of an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.

  If a request for transfer to a post-acute care facility and all necessary information to establish medical necessity of the requested service is received before midnight on a particular day, we will make a determination by no later than the end of the next normal business day. If a request is received before midnight on Friday, we will make a determination no later than the next normal business day, which may be the following Monday or Tuesday if we do not conduct normal business over the weekend or on holidays.
- Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. Retrospective utilization review may be conducted on post-service claims in situations where services are not subject to Pre-service review against clinical criteria.

Retrospective utilization review may be conducted in situations where services are not subject to pre-service review against clinical criteria.

If you wish to determine the status or outcome of a clinical review decision you can contact us by calling the telephone number on the back of your ID card or by calling us at 877-760-3322.

In the event of an adverse determination involving clinical review, your treating provider may discuss your case with a Physician reviewer or may seek reconsideration from us. The reconsideration will take place within one working day of your provider's request. If the adverse determination is not reversed on

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reconsideration you may appeal. Your appeal rights are described in (*Section 6: Questions, Complaints and Appeals*). Your right to appeal does not depend on whether or not your provider sought reconsideration.

Quality Assurance Programs

The goal of our Quality Program is to ensure the provision of consistently excellent health care, health information and service to you, enabling you to maintain and improve your physical and behavioral health and well-being. Some components of the quality program are directed to all Covered Persons and others address specific medical issues and providers.

Examples of quality activities in place for all Covered Person's include a systematic review and re-review of the credentials of Network providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, medical records, appointment access, confidentiality, and the appropriate use of drug therapies and new medical technologies.

Activities affecting specific medical issues and providers include disease management programs for those with chronic diseases like asthma, diabetes and congestive heart failure, and the investigation and resolution of quality-of-care complaints registered by individual Covered Persons.

Pre-Existing Conditions

Your coverage in this health plan is not limited based on medical conditions that are present on or before your effective date. This means that your health care services will be covered from the effective date of your coverage in this health plan without a pre-existing condition restriction or a waiting period. But, benefits for these health care services are subject to all provisions of this health plan.

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Section 8: Defined Terms

Acute Treatment Services - 24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the *Department of Public Health,* that provides evaluation and withdrawal management and which may include biopsychosocial assessment, individual and group counseling, psychoeducational groups and discharge planning.

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

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

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

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

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

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

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

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

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

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

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

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).

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- Gamete intrafallopian transfer (GIFT).
- Pronuclear state tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders - any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* including *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

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

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

Clinical Stabilization Services - 24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the *Department of Public Health*, usually following Acute Treatment Services for substance use disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and aftercare planning, for individuals beginning to engage in recovery from addiction.

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.

Community-Based Acute Treatment for Children and Adolescents (CBAT) - mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring, psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services. Whenever a carrier's acute residential treatment program is substantially similar to CBAT, it may be considered to meet the requirements of CBAT.

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

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

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

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

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

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

- 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.

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- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term "child" includes:

- A natural child.
- A stepchild.
- Adoptive children of a policyholder domiciled in the commonwealth or beneficiary of a fund domiciled in the commonwealth immediately from the date of the filing of a petition to adopt under chapter two hundred and ten and thereafter if the child has been residing in the home of the policyholder.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.
- A foster child from the date of the filing of petition for adoption.
- A newborn infant of a dependent from the moment of birth.
- In all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of a policyholder or beneficiary and thereafter.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. We will determine if an order meets the criteria of a *Qualified Medical Child Support Order*.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

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

If payment of a specific premium is required to provide coverage for a child, the Policy or contract may require that notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and payment of the required premium must be furnished to the insurer or indemnity corporation. For the purposes of this section "notification" may mean submission of a claim.

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

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

Designated Diagnostic Provider - a provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.

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

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

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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 including Cellular Therapy, Gene Therapy, or other genetic/molecular therapies; 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 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.

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

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

Eligible Person - a person who meets the eligibility rules determined by the Massachusetts Health Connector. An Eligible Person must live within the Service Area.

Emergency - a medical condition, whether physical, mental or related to a substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a Covered Person in serious jeopardy or to result in causing serious impairment to body function or serious dysfunction of a body organ or part.

With respect to a pregnant woman who is having contractions:

- When there is inadequate time to effect a safe transfer to another hospital before delivery; or
- When transfer may pose a threat to the health or safety of the woman or the unborn child.

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,

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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.

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
   - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
   - Except that coverage is provided for a drug which has been prescribed for treatment of cancer or HIV/AIDS treatment even if the drug has not been approved by the FDA for that indication, if the drug is recognized for the treatment of that indication:
     - In one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI); (2) The *American Medical Association's Drug Evaluations* (AMADE); (3) The *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information* (AHES-DI);
     - In published scientific studies published in any peer-reviewed national professional journal; or
     - By the commissioner of the Massachusetts Division of Insurance.
     - However, there is no coverage for any drug when the FDA has determined its use to be contraindicated.
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.

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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.

Family Support and Training – medically necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

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

SAMPLE

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

In-Home Behavioral Services - a combination of medically necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

- behavioral management monitoring - monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver, and
- behavior management therapy - therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

In-Home Therapy - medically necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting, including:

- ongoing therapeutic training and support – services that support implementation of a treatment plan pursuant to therapeutic clinical intervention that shall include, but not be limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and mental health needs, and
- therapeutic clinical intervention - intervention that shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.

Initial Enrollment Period - the first period of time when Eligible Persons purchases coverage for himself or herself and his or her Dependents, if applicable, under the Policy.

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

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

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

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

SAMPLE

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 Care Coordination for Children and Adolescents - a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. Intensive care coordination is delivered in office, home or other settings, as clinically appropriate.

Intensive Community-Based Acute Treatment (ICBAT) - provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting. Whenever a carrier's acute residential treatment program is substantially similar to ICBAT, it may be considered to meet the requirements of ICBAT.

The following are not considered child-adolescent mental health intermediate care and outpatient services and are not required to be covered by an insured health plan:

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders.
- Tuition-based programs that offer educational, vocational, recreational, or personal development activities, such as a therapeutic school, camp, or wilderness program. The health plan must provide coverage for medically necessary services provided while the individual is in the program, subject to the terms of the member's evidence of coverage including any network requirements or co-payments/coinsurance provisions.
- Programs that provide primarily custodial care services.

Intensive Outpatient Program(s) - a structured outpatient treatment program.

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

Intermediate Care - A range of non-inpatient Mental Health or Substance Use Disorder services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Care encompasses the following:

- Care at a Residential Treatment Facility, including crisis stabilization and clinically managed detoxification services.
- Care at a Partial Hospitalization/Day Treatment program.

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- Care through an Intensive Outpatient Treatment program, including in-home therapy services.
- For the purposes of this definition:
- "Crisis stabilization" means short-term psychiatric treatment in structured, community-based therapeutic environments. Community crisis stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.
- "Clinically managed detoxification services" means 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that includes 24 hours per day supervision, observation and support, and nursing care, seven days a week.
- "In-home therapy services" means an intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.
- The following are not considered intermediate services and are not covered:
- Programs in which the patient has a pre-defined duration of care without our ability to conduct concurrent determinations of continued medical necessity.
- Programs that only provide meeting or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. Coverage will be provided for medically necessary outpatient or intermediate services provided while the individual is in the program, subject to the provisions described in the *Policy*, *Section 1: Covered Health Care Services*.
- Programs that provide primarily custodial care services.

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.

Licensed Mental Health Professional - a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

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*.

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

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

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

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

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

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

Mental Health Wellness Examination – a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

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.

Mobile Crisis Intervention - a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk

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management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.

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 by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers by or under the direction of your Primary Care Provider. 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.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy.

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you 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 chiropractor, clinical social worker, nurse, mental health clinical specialist, mental health counselor, dentist, certified registered nurse anesthetist, certified nurse midwife, nurse practitioner, obstetrician, optometrist, pediatrician, Physician assistant, podiatrist, psychologist, psychiatry, marriage and family therapist within the lawful scope of practice for such therapist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

- *Policy*.
- *Schedule of Benefits*.
- Policyholder's *Application*.
- Riders.

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- 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.

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

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

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

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

Primary Care Provider - a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice. For Massachusetts residents, this also includes Participating Nurse Practitioners and Physician Assistants.

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

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

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from the Massachusetts Health Connector.

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

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

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

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

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

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

Resident - a natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a Resident.

Residential Treatment - a program of Mental Health Care Services or Substance-Related and Addictive Disorders Services that meets all of the following requirements:

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

Residential Treatment Facility – a Hospital or facility that provides Residential Treatment that is licensed and operated as required by law.

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

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

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

Service Area - the geographic area we serve, where we act as a Qualified Health Plan Issuer as which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third party vendor. When this program applies, the out-of-Network provider's billed charges will

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be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.
- The median amount negotiated with Network providers for the same or similar service.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. Shared Savings Program providers are not Network providers and are not credentialed by us.

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.

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

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

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

Substance Use Disorder Treatment - include early intervention services for substance use disorder treatment; outpatient services including medically assisted therapies; intensive outpatient and partial hospitalization services; certain residential or inpatient services; and certain medically managed intensive inpatient services.

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

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating

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facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Mentoring Services - medically necessary services provided to a child, designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis; provided, however, that such services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

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

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

Unproven Service(s) - services, including medications and devices, that are not determined to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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

Please note:

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

Urgent Care Center - an entity that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

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Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this *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. 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts, to the extent permitted by law; group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital Indemnity benefits coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received; Medicare supplement policies; school accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a 24 hour basis or on a "to and from school" basis; benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; a state plan under Medicaid; or a governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

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

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

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it

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determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major

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medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

3. **Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.** If a person who has a health benefit plan and a motor vehicle insurance policy incurs expenses or requires services as a result of an accident with a motor vehicle: personal injury protection, as defined by M.G.L. c. 90, section 34A, shall always be primary and pay the first $2,000 of expenses as allowed under said statute. PIP shall thereafter be secondary to any such health benefit plan(s) and shall coordinate with the health benefit plan(s) pursuant to M.G.L. c. 90, sections 34A and 34M. Medical payments coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any health benefit plan or personal injury protection as defined under 211 CMR 38.00.

4. **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.

5. **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.

6. **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.

7. 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.

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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: Consolidated Appropriations Act Summary

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

No Surprises Act

Balance Billing

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

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

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

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

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

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

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

Continuity of Care

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

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network

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provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network provider.

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UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

Disclosure of Minimum Creditable Coverage Standards



This benefit plan design meets Minimum Creditable Coverage (MCC) standards and will satisfy the individual Massachusetts mandate that you have health insurance. Please see below for additional information.

Massachusetts Requirement to Purchase Health Insurance:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage (MCC) standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at 1-877-MA-ENROLL or visit the Connector website at www.mahealthconnector.org.

This benefit plan design meets MCC standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase (or, if this health plan is offered to you through your place of employment, your employer purchases) this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Regional Provider Network

This plan provides access to a network that is smaller than UnitedHealthcare's Choice provider network. Under this plan, you have access to Network Benefits only from the providers in the Navigate Network. Please consult the Navigate provider directory or visit the provider search tool at www.myuhc.com to determine which providers are included in the Navigate Network.

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UnitedHealthcare Insurance Company

Navigate

Individual Exchange Medical Policy

Schedule of Benefits

Standard High Bronze HSA: UHC Navigate HSA Bronze 5000

MA0001, $5,000

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How Do You Access Benefits?

Selecting a Network Primary Care Provider

You must select a Network Primary Care Provider in order to obtain Benefits. In general health care terminology, a Primary Care Provider may also be referred to as a *PCP*. A Network Primary Care Provider will be able to coordinate all Covered Health Care Services and submit electronic referrals online to UnitedHealthcare for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Provider for that child. If you do not select a Network Primary Care Provider for yourself or your Enrolled Dependent child, one will be assigned.

You may select any Network Primary Care Provider who is accepting new patients. 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 Provider for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Network Primary Care Provider and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

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

You may change your Network Primary Care Provider by calling the telephone number shown on your ID card or by going to www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

Covered Health Care Services must be provided by or referred by your Primary Care Provider. If care from another Network Physician is needed, your Primary Care Provider will submit an electronic referral online to UnitedHealthcare for services from that other Physician. The electronic referral must be received by UnitedHealthcare before the services are rendered. If you see a Network Physician without an electronic referral from your Primary Care Provider, you will be responsible for all charges and no Benefits will be paid, regardless of the place of service. This includes responsibility for charges for all related services and facility charges received from the Network Physician without the required referral. You should confirm what referrals have been submitted for you and the number of remaining visits on each referral by going to www.myuhc.com. You do not need a referral to see a Network obstetrician/gynecologist or to receive services through the Mental Health/Substance-Related and Addictive Disorders Delegate.

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

You must see a Network Physician in order to obtain Benefits. 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.

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*.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 8: Defined Terms* of the *Policy* for details about how the Shared Savings Program applies.

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.

Does Prior Authorization Apply?

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

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

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

What Will You Pay for Covered Health Care Services?

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

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.

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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 Drug Rider.* Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments and/or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*, the *Pediatric Vision Care Services Rider, and the Pediatric Dental Services Rider*. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, when applicable.	$8,700 per Covered Person, not to exceed $17,400 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

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Payment Term And Description	Amounts
Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

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Schedule of Benefits Table

Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* None	Yes	Yes
	Air Ambulance None	Yes	Yes
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* None	Yes	Yes
	Air Ambulance None	Yes	Yes
2. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies			
Cellular Therapy, Gene Therapy, or other genetic/molecular therapy services must be received from a Designated Provider. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services and preservice management will be the same as those stated under	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.*		

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Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
each Covered Health Care Service category in this *Schedule of Benefits*.			
3. 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*.		
4. Congenital Heart Disease (CHD) Surgeries			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
5. Dental Services - Anesthesia and Facility Charges			
	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*.		

SAMPLE

Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
6. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.* Benefits for blood glucose monitors will be same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
You must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	20%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within two business days. Notification provided to us by the attending physician will satisfy the requirement. Upon request by you or your treating Physician, we may assist in facilitating a transfer to a Network Hospital as soon as it	*Facility Services* $750 per visit	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.			
	Physician Services None	Yes	Yes
9. Enteral Nutrition			
	None	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Benefits are limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she	None	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
is enrolled for coverage under the Policy.			
11. 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 Drug Rider*.		
12. Habilitative Services			
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies are limited per year as follows: • 44 visits of physical therapy. • 44 visits of occupational therapy. • Unlimited Manipulative Treatments. • Unlimited visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive therapy. Limits above do not apply to the treatment of Mental Illness	*Outpatient* $80 per visit for Manipulative Treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider $80 per visit for all other habilitative services	Yes	Yes

SAMPLE

Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Policy*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
or substance-related and addictive disorders.			
13. Hearing Aids			
Note: Limited to $2,000 per hearing aid per hearing impaired ear every 36 months. The difference above the limit of $2,000 will be payable by the insured if the insured elects to pay the difference.	None	Yes	Yes
14. Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify.	None	Yes	Yes
15. Hospice Care			
	None	Yes	Yes
16. Hospital - Inpatient Stay			
Note: Any deductible, Co-payment, and/or Co-insurance, whichever applies to you, will be waived for a sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	$1,000 per Inpatient Stay	Yes	Yes
17. Infertility Services			
	None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider or when	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	services are provided by an obstetrician or gynecologist		
18. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient			
	$55 per service at a freestanding lab or in a Physician's office	Yes	Yes
	$55 per service at a Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient			
	$120 per service at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	$120 per service at an outpatient Hospital-based diagnostic center	Yes	Yes
Diagnostic and supplemental breast screenings	None	Yes	Yes
19. Major Diagnostic and Imaging - Outpatient			
	$500 per service at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	$500 per service at an outpatient Hospital-based diagnostic center	Yes	Yes
Screening breast MRIs	None	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
20. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient (includes Residential Treatment) $1,000 per Inpatient Stay	Yes	Yes
	Outpatient ***Outpatient Office Visit*** $50 per visit	Yes	Yes
	Outpatient Other *Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* None	Yes	Yes
	Intensive Behavioral Therapy None	Yes	Yes
	All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment $50 per session	Yes	Yes
21. Obesity - Weight Loss Surgery			

SAMPLE

Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Obesity - weight loss surgery 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*.		
22. Ostomy Supplies			
	None	Yes	Yes
23. Pharmaceutical Products - Outpatient			
	None None for oral chemotherapeutic agents	Yes	Yes, except for oral chemotherapeutic agents
24. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Inpatient*		
	None	Yes	Yes
	Outpatient		
	None at a freestanding center or in a Physician's office with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Provider in that year	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None at an outpatient Hospital-based center with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Provider in that year	Yes	Yes
25. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.	$50 per visit for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist $80 per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider None for services provided by any other Network Physician with a referral from your Primary Care Provider	Yes Yes Yes	Yes Yes Yes

SAMPLE

Note: Referrals as described in this table must be submitted electronically by your Primary Care Provider before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. **Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above.			
Diagnostic examinations for breast cancer	None	Yes	Yes
26. Pregnancy - Maternity Services Includes Childbirth Classes			
	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.		
Doula Services Benefits for doula services are limited to the following: • A combined limit of eight (8) hours for prenatal/postnatal services.	None	Yes	No

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• One (1) labor/delivery visit, and • Services within 12 months of diagnosis.			
27. Preimplantation Genetic Testing (PGT) and Related Services			
	None	Yes	Yes
28. Preventive Care Services Includes: • Fitness Benefit • Weight Loss Program Benefit			
Physician office services	None for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider	Yes	No
Lab, X-ray or other preventive tests	None for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider	Yes	No
Breast pumps	None	Yes	No

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
29. Prosthetic Devices			
	20%	Yes	Yes
30. 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*.		
31. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 20 visits of pulmonary rehabilitation therapy. • Unlimited visits of cardiac rehabilitation therapy. • 44 visits of physical therapy. • 44 visits of occupational therapy. • Unlimited Manipulative Treatments. • Unlimited visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	$80 per visit for Manipulative Treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Provider $80 per visit for all other rehabilitation services	Yes	Yes
Limits above do not apply to the treatment of Mental Illness			

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
or substance-related and addictive disorders.			
32. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	\$500 per date of service for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist \$500 per date of service for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Provider	Yes	Yes
33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
• 100 days per year in a Skilled Nursing Facility. • 60 days per year in an Inpatient Rehabilitation Facility.	\$1,000 per Skilled Nursing Facility Inpatient Stay \$1,500 per Inpatient Rehabilitation Facility Stay	Yes	Yes
34. Surgery - Outpatient			
Note: Any deductible, Co-payment, and/or Co-insurance, whichever applies to you, will be waived for a sterilization procedure for a female member when performed as the primary procedure for family planning reasons.	\$500 per date of service at an ambulatory surgical center or in a Physician's office for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	$500 per date of service at an ambulatory surgical center or in a Physician's office for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Provider		
	$500 per date of service at an outpatient Hospital-based surgical center for services provided by your Primary Care Provider or by a Network obstetrician or gynecologist $500 per date of service at an outpatient Hospital-based surgical center for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Provider	Yes	Yes
35. Temporomandibular Joint (TMJ) 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.*		
36. Therapeutic Treatments - Outpatient			
	None	Yes	Yes
37. Transplantation Services			

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Transplantation services must be received from a Designated Provider. We do not require that cornea transplants 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.*		
38. Urgent Care Center Services			
Benefits are available for out-of-Network Urgent Care Center services.	*Network* $80 per visit	Yes	Yes
	Out-of-Network $80 per visit	Yes	Yes
39. Urinary Catheters			
	None	Yes	Yes
40. Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	$80 per visit	Yes	Yes
Additional Benefits Required by Massachusetts Law			
41. Abortion and Abortion-Related 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*.		

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
42. Autism Spectrum Disorder Treatment			
Limits stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in your *Schedule of Benefits* do not apply to *Autism Spectrum Disorder 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.*		
43. COVID-19 Testing and 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*.		
44. Down Syndrome 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.*		
45. Early Intervention Services			
	None	Yes	Yes
46. HIV-Associated Lipodystrophy 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*.		
47. Hormone Replacement Therapy and Contraceptive Services			

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Depending upon the Covered Health 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.*		
48. Hypodermic Needles and Syringes			
	None	Yes	Yes
49. Opioid Antagonists			
	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*.		
50. Speech, Hearing, and Language Disorders			
	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.*		
51. Treatment of Cleft Lip or Palate or Both			
	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.*		
52. Wigs			
	None	Yes	Yes

Allowed Amounts

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

- For 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.

SAMPLE

- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Policy*.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Policy.*
- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *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, Co-insurance, or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Policy*.

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

For Benefits, Allowed Amounts are based on the following:

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

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

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

SAMPLE

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Policy*.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

For Air Ambulance transportation provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

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

For Urgent Care services provided by an out-of-Network Urgent Care Center, the Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market or an amount negotiated by us and the provider.

When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:

- For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

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

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

Provider Network

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

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

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

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

Continuity of Care

Network Benefits for continued treatment are provided in the following situations:

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- If a Covered Person is in her second or third trimester of pregnancy and receiving obstetrical care from a provider who is involuntarily disenrolled from the Network, other than disenrollment for quality-related reasons or for fraud, the Covered Person may continue to be treated by that provider for that pregnancy up to and including the first postpartum visit.

  If a Covered Person is receiving care for a terminal illness from a provider who is involuntarily disenrolled from the Network, other than disenrollment for quality-related reasons or for fraud, the Covered Person may continue to be treated by that provider until the Covered Person's death.

This Continued Treatment provision only applies if the provider agrees to the following three conditions:

- To accept reimbursement from us at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled.
- To adhere to our quality assurance standards and to provide us with necessary medical information related to the care provided.
- To adhere to our policies and procedures, including procedures regarding referrals, obtaining prior authorization and services provided pursuant to a treatment plan, if any, approved by us.

This Continued Treatment provision will not be construed to require the coverage of Benefits that would not have been covered if the provider involved remained a Network provider.

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

Designated Providers

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

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

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

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

If a Covered Health Care Service is not available from a Network provider, in this situation, your Primary Care Provider will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Provider to coordinate care through an out-of-Network provider. We will cover the out-of-Network Covered Health Care Service and you will not be responsible to pay more than the amount which would be required for a similar Covered Health Care Service offered within our network. In addition, whenever a location is part of our network, we will cover a Covered Health Care Service delivered at that location and you will not be responsible to pay more than the amount required for Network services even if part of the Covered Health Care Service is performed by out-of-Network providers, unless you had a reasonable opportunity to choose to have the service performed by a Network provider.

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Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

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

UnitedHealthcare Insurance Company



Robert Hunter, President

SAMPLE

Introduction

Coverage Policies and Guidelines

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

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

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

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

- Coverage for prescription contraceptive drugs approved by the *Food and Drug Administration*. Benefits defined under the Health Resources and Services Administration (HRSA) requirement include, but may be limited to the full range of *FDA* approved contraceptive methods without cost sharing. Benefits include at least one form of contraception in each of the methods (currently 18) that the *FDA* has identified in its current Birth Control Guide. These methods are including, but not limited to, hormonal methods, such as oral contraceptives, and oral medications for emergency contraception.
- Benefits for Prescription Drug Products are available for pharmacotherapy when prescribed by a Physician for tobacco cessation treatment and are limited to:
- Two 90-day courses of pharmacotherapy per Covered Person per year.
- Initiation of any course of pharmacotherapy will be considered an entire course of pharmacotherapy, even if a Covered Person discontinues or fails to complete the course.
- For the purposes of this Rider, "pharmacotherapy" means the use of first-line drugs, approved by the *U.S. Food and Drug Administration (FDA)* and available by prescription only, to assist in the cessation of tobacco use or smoking.
- Benefits for pharmacotherapy for tobacco cessation treatment are subject to all applicable requirements of this Rider.

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

Identification Card (ID Card) - Network Pharmacy

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

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

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

Submit your claim to:

Optum Rx

PO Box 650540

Dallas, TX 75265-0540

Designated Pharmacies

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

If you are directed to a Designated Pharmacy and do not obtain your Prescription Drug Product from a Designated Pharmacy, no Benefits will be paid for that Prescription Drug Product.

If you choose to obtain Specialty Prescription Drug Products that are available from a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Pharmacy Co-payment and/or Co-insurance.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. We may pass a portion or all of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. We are not required to pass on to you, and do not pass on to you, such amounts.

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Coupons, Incentives and Other Communications

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

Variable Co-payment Program

Certain Prescription Drug Products, including Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

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

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications.

Prescription Drug Products Prescribed by a Specialist

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

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Section 1: Benefits for Prescription Drug Products

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

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception; provide hormone replacement therapy for peri and post-menopausal women; or orally administered anticancer medication used to kill or slow the growth of cancerous cells.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. Please see *Designated Pharmacies* above.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

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

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

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

Depending upon your plan design, this *Outpatient Prescription Drug Rider* 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.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

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Section 2: Exclusions

Exclusions from coverage listed in the Policy also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational Services and medications used for experimental or investigational treatments for specific diseases and/or dosage regimens determined by us to be experimental or investigational.
7. Unproven Services and medications; medications used for unproven treatments for specific diseases and/or dosage regimens determined by us to be unproven.
8. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
9. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
10. Any product dispensed for the purpose of appetite suppression or weight loss.
11. A Pharmaceutical Product for which Benefits are provided in your Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
12. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
13. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
14. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as a unit dose(s).
15. Prescription Drug Products used for cosmetic or convenience purposes.
16. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Care Service.

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17. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

18. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.

19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

20. The following over-the-counter drugs and products:

    - Drugs or products 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 drug or product 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.
    - Over-the-counter continuous glucose monitors; and

    The following Prescription Drug Products with over-the-counter alternatives;

    - 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. Such determinations may be made up to six times during a calendar year.
    - Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

    We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain New Prescription Drug Products the date they are reviewed and placed on a tier by our PDL Management Committee and applicable clinical criteria are approved.

22. 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).

23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Prescription Drug Products that are the following, as described in the *Policy Section 1: Covered Health Services, Enteral Nutrition:*

    - Non-prescription enteral formulas for home use when ordered by a Physician for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.
    - Food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acids.
    - Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria when prescribed by a Physician.

24. A particular Therapeutic Class or Therapeutic Classes. Please contact us at www.myuhc.com or the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.

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25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in the *Certificate* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

28. Certain Prescription Drug Products that have not been prescribed by a Specialist.

29. A Prescription Drug Product that contains marijuana, including medical marijuana.

30. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

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

32. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*.

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

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

33. Diagnostic kits and products, including associated services.

34. 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*.

35. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

36. Prescription Drug Products prescribed by a provider who is on our list of excluded providers due to fraud, waste, and/or abuse findings.

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Section 3: Defined Terms

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

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

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

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

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

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

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 Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product, 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 Management Committee.

SAMPLE

- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible, or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Certain immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

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

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

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

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

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

- Inhalers (with spacers).
- Insulin and insulin pens.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;

SAMPLE

- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices;
- blood glucose monitors;
- prescribed oral diabetes medication that influence blood sugar levels; and
- glucose meters, including stand-alone continuous glucose monitors.

A stand-alone continuous glucose monitor is one that does not require integration with other diabetes management systems such as an insulin pump.

Benefits for continuous glucose monitors that require integration with an insulin pump are provided as described in the *Policy*.

- A drug which has been prescribed for treatment of cancer or HIV/AIDS treatment even if the drug has not been approved by the FDA for that indication, if the drug is recognized for the treatment of that indication:
  - In one of the following established reference compendia:
    - The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI);
    - The American Medical Association's Drug Evaluations (AMADE);
    - The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI); or
    - For off-label uses of prescription drugs for the treatment of cancer only, the Association of Community Cancer Centers' Compendia-Based Drug Bulletin.
  - Scientific studies in any peer-reviewed national professional journal.
  - By the commissioner of the Massachusetts Division of Insurance.
  - However, there is no coverage for any drug when the FDA has determined its use to be contraindicated.

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

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

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical Products as described in the *Certificate* have essentially the same efficacy and adverse effect profile.

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

SAMPLE

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying, in addition to any applicable Ancillary Charge, the higher of:

- The applicable Co-payment and/or Co-insurance at the highest tier as described in the *Outpatient Prescription Drug Schedule of Benefits*, or
- A Co-insurance of 50%.

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 exclusion 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 exclusion 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.

SAMPLE

Section 5: Your Right to Request an Exception for Contraceptives

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

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

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

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

SAMPLE

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

Benefits are available for opioid antagonists used for the reversal of overdoses caused by opioids when dispensed by a pharmacist. You do not need a prescription from a Primary Care Provider to receive this Benefit, and prior authorization is not required.

We will provide full coverage for certain opioid antagonists except when you are enrolled in a high deductible health plan with a health savings account. In this case, your deductible may apply before you receive full coverage.

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

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

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

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

How Do Supply Limits Apply?

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

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed. For Prescription Drug Products that allow a 90-day fill, you may be required to obtain a limited number of up to 31-day fills until the maintenance dose is established.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

SAMPLE

Do Prior Authorization Requirements Apply?

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

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

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

Network Pharmacy Prior Authorization

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

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

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or Pharmaceutical Product(s) for which Benefits are provided as described under the *Certificate* first.

You or your prescribing health care provider may request an exception to step therapy requirements through the Prior Authorization process. An exception to step therapy requirements will be granted if any of the following apply:

- The prescription drug required under the step therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm.
- The prescription drug required under the step therapy protocol is expected to be ineffective, based on both of the following:

SAMPLE

- Your known clinical characteristics; and
- The known characteristics of the prescription drug regimen;

- You or your prescribing health care provider have provided documentation establishing that you have previously:
  - Tried the prescription drug required under the step therapy protocol or another prescription drug in the same pharmacologic class or with the same mechanism of action; and
  - Such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or
- You or your prescribing health care provider have provided documentation establishing that:
  - You are stable on the requested prescription drug prescribed by your health care provider; and
  - Switching drugs will likely cause an adverse reaction or physical or mental harm.

We will notify you and your prescribing health care provider of our determination for a step therapy review within three (3) business days for non-urgent care situations or within 24 hours for urgent care situations after receiving a request. Any denial notice of a step therapy request will include a detailed, written explanation of the reason for the denial and the clinical rationale supporting the denial.

Continuity of Coverage: Upon request, you will be allowed a 30-day fill of a covered medication, on which you have already been prescribed and are stable, while the step therapy exception request is being reviewed.

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

What Do You Pay?

You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your Policy before Benefits for Prescription Drug Products under this Rider are available to you. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.

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

Benefits for Prescription Drug Products on the List of Zero Cost Share Medications are not subject to payment of the Annual Deductible unless required by state or federal law.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-Payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Deductible or Out-of-Pocket Limit.

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

- Ancillary Charges.

SAMPLE

- 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.

SAMPLE

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin to treat diabetes will not exceed the amount allowed by applicable law. In accordance with the *MA PACT ACT*, please review the list of	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

SAMPLE

Payment Term And Description	Amounts
insulin medications to treat diabetes by visiting www.myuhc.com or calling the telephone number on your ID card. **Special Programs**: We may have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program**: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist**: You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE**: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.	

SAMPLE

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

SAMPLE

Schedule of Benefits Information Table

- Your Co-payment and/or Co-insurance is determined by Prescription Drug Products on the Prescription Drug List placed on the tiers outlined in the table below.
- Prescription Drug Products supply limit:
  - Retail Network Pharmacy – 31 or 90 days
  - Mail Order Network Pharmacy – 90 days
  - Specialty and Opioid Prescription Drug Products at a Network Pharmacy – 31 days
  - A 12-month supply of a contraceptive. You may obtain an initial 3-month supply for any new contraceptive prescription. Thereafter, you may obtain a single 12-month supply for any such prescription per plan year.
- Ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, not 31-day supply with three refills.
- You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.

AMOUNTS SHOWN ARE YOUR COST RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN MET			
The amounts you are required to pay as shown below are based on the Prescription Drug Charge.			
	Retail Network Pharmacy		Mail Order Network Pharmacy
	31-Day Supply	90-Day Supply	90-Day Supply
Tier 1	$30 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$30 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$60 per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 2	$100 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$200 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$200 per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 3	$200 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$600 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$600 per Prescription Order or Refill. Subject to payment of the Annual Deductible.

SAMPLE

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

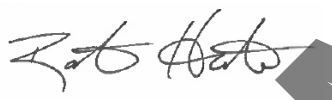
This Rider to the Policy provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Massachusetts Health Connector.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Dental Services.*

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

UnitedHealthcare Insurance Company



Robert Hunter, President

SAMPLE

Section 1: Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental 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 Services to be paid, you must obtain all Covered Dental 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 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 Services that are not provided by a Network Dental Provider.

What Are Covered Dental Services?

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

Benefits are available only for Necessary Dental 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 Rider.

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 Services are provided. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

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

A. Necessary.

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

SAMPLE

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 *Section 3: Pediatric Dental Exclusions* of this Rider.

Benefits:

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

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

Annual Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the *Schedule of Benefits*, unless otherwise specifically stated.

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

Benefits

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

Benefit Description

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)	
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation. D0140 - Limited oral evaluation - problem focused. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review.	None

SAMPLE

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

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D0706 - Intraoral - occlusal radiographic image - image capture only. D0707 - Intraoral - periapical radiographic image - image capture only.	
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image. D0272 - Bitewings - two radiographic images. D0274 - Bitewings - four radiographic images. D0277 - Vertical bitewings - 7 to 8 radiographic images. D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images. D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only. D0708 - Intraoral - bitewing radiographic image - image capture only.	None
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image. D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only.	None
The following service is limited to two images per calendar year. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement, and analysis. D0350 - 2-D Oral/facial photographic images obtained intra-orally or extra-orally. D0470 - Diagnostic casts. D0703 - 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 two times every 12 months. D1110 - Prophylaxis - adult. D1120 - Prophylaxis - child.	None
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish. D1208 - Topical application of fluoride - excluding varnish.	None
Sealants (Protective Coating) The following service is limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth.	None
Space Maintainers (Spacers) The following services are not subject to a frequency limit.	None

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D1510 - Space maintainer - fixed, unilateral - per quadrant. D1516 - Space maintainer - fixed - bilateral, maxillary. D1517 - Space maintainer - fixed - bilateral, mandibular. D1520 - Space maintainer - removable, unilateral - per quadrant. D1526 - Space maintainer - removable - bilateral, maxillary. D1527 - Space maintainer - removable - bilateral, mandibular. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1556 - Removal of fixed unilateral space maintainer - per quadrant. D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.	
Minor Restorative Services - (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D2140 - Amalgams - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces, primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.	
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior. D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces (anterior). D2989 - Excavation of a tooth resulting in the determination of non-restorability.	20%
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)	
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four or more surfaces. D2740 - Crown - porcelain/ceramic. D2750 - Crown - porcelain fused to high noble metal.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. D2753 - Crown - porcelain fused to titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2930 - Prefabricated stainless steel crown - primary tooth. D2931 - Prefabricated stainless steel crown - permanent tooth. The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement or re-bond inlay. D2920 - Re-cement or re-bond crown.	
The following service is not subject to a frequency limit.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D2940 - Protective restoration.	
The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins when required. D2951 - Pin retention - per tooth, in addition to restoration.	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair necessitated by restorative material failure. D2982 - Onlay repair necessitated by restorative material failure.	50%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration). D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration). D3320 - Endodontic therapy, premolar tooth (excluding final restoration). D3330 - Endodontic therapy, molar tooth (excluding final restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - premolar. D3348 - Retreatment of previous root canal therapy - molar.	20%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement. D3353 - Apexification/recalcification - final visit.	20%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior. D3421 - Apicoectomy - premolar (first root). D3425 - Apicoectomy - molar (first root). D3426 - Apicoectomy (each additional root).	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D3450 - Root amputation - per root. D3471 - Surgical repair of root resorption - anterior. D3472 - Surgical repair of root resorption - premolar. D3473 - Surgical repair of root resorption - molar. D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier. D3920 - Hemisection (including any root removal), not including root canal therapy.	20%
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	20%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
more contiguous teeth or tooth bounded spaces per quadrant. D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. D4249 - Clinical crown lengthening - hard tissue.	
The following services are limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. D4263 - Bone replacement graft - retained natural tooth - first site in quadrant. D4286 - Removal of non-resorbable barrier.	20%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure.	20%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft. D4275 - Non-autogenous connective tissue graft first tooth implant. D4277 - Free soft tissue graft procedure - first tooth.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D4278 - Free soft tissue graft procedure - each additional contiguous tooth. D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns. D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.	
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	20%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	20%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance.	20%
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular. D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including	

SAMPLE

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

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture (each tooth). D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5621 - Repair cast partial framework - mandibular. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken retentive/clasping materials - per tooth. D5640 - Replace broken teeth - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture.	
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture. D5711 - Rebase complete mandibular denture. D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5725 - Rebase hybrid prosthesis. D5730 - Reline complete maxillary denture (direct).	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic complete denture (per arch).	
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%
Bridges (Fixed partial dentures (FPD) - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic - titanium and titanium alloys.	50%

SAMPLE

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

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6783 - Retainer crown - 3/4 porcelain/ceramic. D6784 - Retainer crown - 3/4 titanium and titanium alloys. D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.	
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD. D6980 - FPD repair necessitated by restorative material failure.	50%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony. D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only.	
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	20%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth.	20%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	20%
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible).	20%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D7510 - Incision and drainage of abscess, intraoral soft tissue. D7910 - Suture of recent small wounds up to 5 cm. D7953 - Bone replacement graft for ridge preservation - per site. D7961 - Buccal/labial frenectomy (frenulectomy). D7962 - Lingual frenectomy (frenulectomy). D7971 - Excision of pericoronal gingiva.	
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site. D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	20%
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. D9110 - Palliative treatment of dental pain - per visit.	20%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minute increment, or any portion thereof. D9223 - Deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D9224 - Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof. D9225 - Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof. D9239 - Administration of moderate sedation/ - intravenous - first 15 minute increment, or any portion thereof. D9244 - In-office administration of minimal sedation - single drug - enteral. D9245 - Administration of moderate sedation - enteral. D9246 - Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof D9247 - Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof. D9610 - Therapeutic parenteral drug single administration.	
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	20%
The following services are limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch. D9945 - Occlusal guard - soft appliance, full arch.	20%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D9946 - Occlusal guard - hard appliance, partial arch.	
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Surgical placement of eposteal implant. D6049 - Scaling and debridement of a single implant in the presence of peri-implantitis inflammation. D6050 - Surgical placement: transosteal implant. D6055 - Connecting bar - implant supported or abutment supported. D6056 - Prefabricated abutment - includes modification and placement. D6057 - Custom fabricated abutment - includes placement. D6058 - Abutment supported porcelain/ceramic crown. D6059 - Abutment supported porcelain fused to metal crown (high noble metal). D6060 - Abutment supported porcelain fused to metal crown (predominately base metal). D6061 - Abutment supported porcelain fused to metal crown (noble metal). D6062 - Abutment supported cast metal crown (high noble metal).	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6063 - Abutment supported cast metal crown (predominately base metal). D6064 - Abutment supported cast metal crown (noble metal). D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys. D6068 - Abutment supported retainer for porcelain/ceramic FPD. D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal). D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal). D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal). D6072 - Abutment supported retainer for cast metal FPD (high noble metal). D6073 - Abutment supported retainer for cast metal FPD (predominately base metal). D6074 - Abutment supported retainer for cast metal FPD (noble metal). D6075 - Implant supported retainer for ceramic FPD. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6077 - Implant supported retainer for metal FPD - high noble alloys. D6080 - Implant maintenance procedure. D6081 - Scaling and debridement of single implant in the presence of mucositis, including inflammation, bleeding upon probing, and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys. D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6089 - Accessing and retorquing loose implant screw per screw. D6090 - Repair of implant/abutment supported prosthesis. D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment. D6096 - Remove broken implant retaining screw.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys. D6100 - Surgical removal of implant body. D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous contouring of a peri-implant defect. D6103 - Bone graft for repair peri-implant defect. D6104 - Bone graft at time of implant replacement. D6105 - Removal of implant body not requiring bone removal nor flap elevation. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular. D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D6190 - Radiographic/surgical implant index, by report. D6191 - Semi-precision abutment - placement. D6192 - Semi-precision attachment - placement. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys. D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant. D6280 - Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch.	
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant. D6107 - Guided tissue regeneration - non-resorbable barrier, per implant.	50%
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 handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.	
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy. D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
D8698 - Re-cement or re-bond fixed retainer - maxillary. D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary. D8702 - Repair of fixed retainer, includes reattachment - mandibular.	

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Pediatric Dental Services*, Benefits are not provided under this Rider for the following:

1. Dental Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Pediatric Dental Services*.
3. Dental Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

SAMPLE

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.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.
17. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental 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 unless required as an Emergency.
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.

Section 4: Defined Terms for Pediatric Dental 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 Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider.

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

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 Services, perform dental surgery or provide anesthetics for dental surgery.

Dental 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 Services and supplies under this Rider 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.

SAMPLE

- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental 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 Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

SAMPLE

Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Massachusetts Health Connector.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Policy* in *Section 8: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services.*

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

UnitedHealthcare Insurance Company



Robert Hunter, President

SAMPLE

Section 1: Benefits for Pediatric Vision Care Services

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 1-800-839-3242. You may also access a listing of Spectera Eyecare Network Vision Care Providers on the Internet at www.myuhc.com.

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

[1]When obtaining these Vision Care Services from a Spectera Eyecare Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Benefits:

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

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

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the *Schedule of Benefits* unless otherwise specifically stated.

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 and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Exam

A routine vision exam of the eyes 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.

SAMPLE

- Photometry/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.

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.

SAMPLE

- 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.
- Follow-up care: Four visits in any five-year period.

Schedule of Benefits

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.	$30 per exam. Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		50%
• Bifocal		50%
• Trifocal		50%
• Lenticular		50%
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.
• Blended Segment Lenses		

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Intermediate Vision Lenses • Standard Progressives • Premium Progressives • Photochromic Glass Lenses • Plastic Photosensitive Lenses • Polarized Lenses • Hi-index Lenses • Standard Anti-Reflective Coating • Premium Anti-Reflective Coating • Ultra Anti-Reflective Coating • Ultraviolet Protective Coating • Tinted Lenses • Oversized Lenses		80% of the billed charge.
Eyeglass Frames	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		50%
• Eyeglass frames with a retail cost of $130 - 160.		50%
• Eyeglass frames with a retail cost of $160 - 200.		50%
• Eyeglass frames with a retail cost of $200 - 250.		50%
• Eyeglass frames with a retail cost greater than $250.		50%

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Contact Lenses Fitting, Evaluation and Follow-Up Care		
• Contact Lenses Fitting, Evaluation and Follow-Up Care	Once every 12 months	None Not subject to payment of the Annual Deductible.
• Covered Contact Lens Selection	Limited to a 12 month supply.	50%
Necessary Contact Lenses	Limited to a 12 month supply.	50%
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months	
• Low vision testing		None Not subject to payment of the Annual Deductible.
• Low vision therapy		25% of billed charges Not subject to payment of the Annual Deductible.
• Follow-up care	Four visits in any five-year period	25% of billed charges Not subject to payment of the Annual Deductible.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services*, Benefits are not provided under this Rider 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.

SAMPLE

5. Optional Lens Extras not listed in *Section 1: Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Low Vision Care Services

When obtaining low Vision Care Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, 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 provided by Spectera Eyecare Network Vision Care Provider, you must provide all of the following information on a claim form acceptable to us:

- 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

Section 4: 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 Selection - 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 Vision Care Provider - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the *Policy*.

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

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services.*

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 እትም 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.

SAMPLE

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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