UnitedHealthcare of North Carolina, Inc.

Individual Exchange Medical Policy

3803 North Elm Street
Greensboro, NC 27455
800-980-5357

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

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

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

SAMPLE

UnitedHealthcare of North Carolina, Inc.

Individual Exchange Medical Policy

Agreement and Consideration

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

Guaranteed Renewable Subject to Listed Conditions

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

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

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

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

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

10-Day Right to Examine and Return this Policy

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

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

UnitedHealthcare of North Carolina, Inc.

Laurie Mandell

Laurie Mandell, President and CEO

SAMPLE

UnitedHealthcare Individual Exchange Medical Policy

UnitedHealthcare of North Carolina, Inc.

Schedule of Benefits

Covered Health Care Services Schedule of Benefits

UHC Silver Value ($0 Virtual Urgent Care, $5 Tier 2 Rx, $0 Insulin, No Referrals)

NC0005, $3,550

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician, who is in the Network Area and accepting new patients, in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP.* A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care.

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

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

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

Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from a UnitedHealthcare Individual Exchange Benefit Plan provider. You can confirm that your provider is a UnitedHealthcare Individual Exchange Benefit Plan provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com/exchange. You should confirm that your provider is a UnitedHealthcare Individual Exchange Benefit Plan provider.

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

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

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

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

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

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

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

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

Care Management

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

Does Prior Authorization Apply

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

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

What Will You Pay for Covered Health Care Services?

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

Payment Information

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drugs* section. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this Schedule of Benefits including Covered Health Care Services provided under the Pediatric Dental Care Services section and the Pediatric Vision Care Services section. 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	$3,550 per Covered Person, not to exceed $7,100 for all Covered Persons in a family.

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Payment Term And Description	Amounts
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. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drugs s*ection. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including the *Pediatric Dental Care Services s*ection and the *Pediatric Vision Care Services s*ection. 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. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	$11,200 per Covered Person, not to exceed $22,400 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.	

SAMPLE

Payment Term And Description	Amounts
Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

SAMPLE

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Ambulance Services			
Emergency Ambulance Services Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance:* 40%	Yes	Yes
	Air Ambulance: 40%	Yes	Yes
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under Allowed Amounts in this *Schedule of Benefits.*	*Ground Ambulance:* 40%	Yes	Yes
	Air Ambulance: 40%	Yes	Yes
Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Dental Anesthesia			
	40%	Yes	Yes
Dental Services - Accident Only			
	40%	Yes	Yes
Diabetes Services			
Diabetes Self-Management and Educational Services For Covered Persons with Type 1 or Type 2 diabetes, the	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*.		

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?**
following services are offered at $0 cost share: • Retinal eye exams, limited to 1 exam per plan year. • Preventive foot care. • Nutritional counseling. • Certain lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HbA1c) in diabetics. This does not apply to Covered Persons with pre-diabetes or gestational diabetes diagnoses.			
Diabetes Self-Management Supplies	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management supplies will be the same as those stated under *Durable Medical Equipment (DME)* and in the *Outpatient Prescription Drugs section.* Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drugs* section.		
Durable Medical Equipment (DME)			
You must purchase or rent the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	40%	Yes	Yes
Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may	*Facility Services* 40%	Yes	Yes
	Physician Services 40%	Yes	Yes

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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?**
elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER Services, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*			
Enteral Nutrition			
	40%	Yes	Yes
Eyeglasses for Disease or Injury			
Benefits are limited to a one-time replacement of eyeglasses or contact lenses when required as a result of prescription change after cataract surgery.	40%	Yes	Yes
Gender Dysphoria			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Habilitative Services			
	Inpatient		

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Limited per year as follows: • 30 visits for speech therapy. • 30 visits for any combination of physical therapy, occupational therapy and Manipulative Treatment including chiropractic care. Visit limits for therapies do not apply if the primary diagnosis code is for Mental Health, Substance Use Disorder, or Autism Spectrum Disorder.	*Outpatient* 40%	Yes	Yes
Hearing Aids			
Limited to one Hearing Aid per hearing-impaired ear every 36 months.	40%	Yes	Yes
Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify.	40% *Private Duty Nursing* 40%	Yes Yes	Yes Yes
Hospice Care			
	40%	Yes	Yes
Hospital - Inpatient Stay			
	40%	Yes	Yes
Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	$15 per service at a freestanding lab or in a Physician's office	Yes	No

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	$75 per service at a Hospital-based lab	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
Lymphedema 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*.		
Major Diagnostic and Imaging - Outpatient			
	40% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
Manipulative Treatments			
Limited to 30 visits for any combination of physical therapy, occupational therapy and Manipulative Treatments including chiropractic care.	40%	Yes	Yes
Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient (includes Residential Treatment)		
	40%	Yes	Yes
	Outpatient		
	40% for Intensive Outpatient Program	Yes	Yes

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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?**
	40% for Partial Hospitalization	Yes	Yes
	40% for all other outpatient services including Intensive Behavioral Therapy, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, and Psychological Testing	Yes	Yes
	Office Visit		
	$40 per visit	Yes	No
Morbid Obesity Surgery			
Morbid Obesity surgery also known as bariatric surgery must be received from a Designated Provider. If you are admitted as an inpatient to a Hospital as a result of your surgery, Benefits provided as described under *Hospital – Inpatient Stay* and/or *Physician Fees for Surgical and Medical Services* may apply.	40% at a freestanding surgical center	Yes	Yes
	40% at an outpatient Hospital-based surgical center	Yes	Yes
Necessary Medical Supplies			
	40%	Yes	Yes
Orthotics			
Benefits include orthotic devices for the correction or positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets.	40%	Yes	Yes
Pharmaceutical Products - Outpatient			

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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?**
Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. **Note**: Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drugs* section.	40%	Yes	Yes
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*. Covered Health Care Services include sterilization, contraceptive device placement and diagnosis or treatment of the underlying cause of infertility or sexual dysfunction.	*Inpatient*		
	40%	Yes	Yes
	Outpatient		
	40% at a freestanding center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based center	Yes	Yes
Physician's Office Services - Sickness and Injury			
Benefits include the facility charge, supplies and all professional services required to treat your condition in a Physician's office. 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:	$40 per visit for services provided by your Primary Care Physician	Yes	No
	$110 per visit for services provided by a Network Specialist	Yes	No
	40% for services provided by any other Network Physician	Yes	Yes

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Covered Health Care Service	**What Is the Co-payment 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?**
• Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.			
Pregnancy - Maternity Services			
	Depending upon where the Covered Health Care Services is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No

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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?**
Breast pumps	None	Yes	No
Prosthetic Devices			
	40%	Yes	Yes
Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 30 visits for speech therapy • 30 visits for any combination of physical therapy, occupational therapy, and Manipulative Treatment, including chiropractic care. Visit limits do not apply for therapies for Covered Persons with a primary diagnosis of Mental Health, Substance Use Disorder or Autism Spectrum Disorder.	40%	Yes	Yes
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	40%	Yes	Yes
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Any combination of Skilled Nursing Facility or Inpatient Rehabilitation Facility Services is limited to 60 days per year.	*Skilled Nursing Facility*		
	40%	Yes	Yes
	Inpatient Rehabilitation Facility		

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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?**
	40%	Yes	Yes
Surgery – Outpatient			
	40% at a freestanding surgical center	Yes	Yes
	40% at an outpatient Hospital-based surgical center	Yes	Yes
Telehealth			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Temporomandibular Joint Syndrome (TMJ)			
	40%	Yes	Yes
Therapeutic Treatments – Outpatient			
	Chemotherapy 40%	Yes	Yes
	Dialysis 40%	Yes	Yes
	Infusion Therapy 40%	Yes	Yes
	Radiation 40%	Yes	Yes
	All Other Treatments 40%	Yes	Yes

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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			
Transplantation services must be received from a Designated Provider. Covered expenses for lodging and ground transportation will be limited to $10,000 per transplant	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Urgent Care Center Services			
Benefits include the facility charge, supplies and all professional services required to treat your condition in an Urgent Care setting. Benefits are available for out-of-Network Urgent Care Center services.	*Network* $60 per visit	Yes	No
	Out-of-Network $60 per visit	Yes	No
Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	*Urgent Care* None	Yes	No

Allowed Amounts

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

- For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians****, you* are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this Policy.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is***

SAMPLE

provided for which notice and consent has been satisfied as described below*, you* are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this Policy.

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this Policy.
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the Policy.

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

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

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

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

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

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

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

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

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

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

SAMPLE

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: You are not responsible for any difference between the provider's billed charges and the Allowed Amount, 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. The Network provider rate is based on the Recognized Amount as defined in the Policy.

Provider Network

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

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

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

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

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

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

SAMPLE

Designated Providers

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

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

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

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Outpatient Prescription Drugs Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

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

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

How Do Supply Limits Apply?

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

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed. You cannot refill a prescription until 75% of the supply has been used except under certain circumstances during a state of emergency or disaster.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

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

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

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

SAMPLE

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you will be responsible for paying all charges and no Benefits will be paid. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. 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/exchange or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

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

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

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 10: Outpatient Prescription Drugs* of the Policy are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

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

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

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier.

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

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

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

Expedited External Review

SAMPLE

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

What Do You Pay?

You are responsible for paying the Annual Deductible stated in this *Schedule of Benefits*, which is part of your Policy, before Benefits for Prescription Drug Products are available to you unless otherwise allowed under your Policy. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

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

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

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

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

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- 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

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

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. **Special Programs**: We may have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. **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.	For Prescription Drug Products at a Retail Network Pharmacy you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You may obtain up to a 30-day supply of insulin products on Tier 1 at a Network Pharmacy at $0 cost to you.

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 – 30 or 90 days
  - Mail Order Network Pharmacy – 90 days
  - Specialty and Opioid Prescription Drug Products at a Network Pharmacy – 30 days
- Ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, not 30-day supply with three refills.
- Please note that you cannot refill a prescription until 75% of the supply has been used, except under certain circumstances during a state of emergency or disaster.
- You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.

AMOUNTS SHOWN ARE YOUR COST RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN MET			
The amounts you are required to pay as shown below are based on the Prescription Drug Charge.			
	Retail Network Pharmacy		Mail Order Network Pharmacy
	30-Day Supply	90-Day Supply	90-Day Supply
Tier 1	None Not subject to payment of the Annual Deductible.	None Not subject to payment of the Annual Deductible.	None Not subject to payment of the Annual Deductible.
Tier 2	$5 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$12.50 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.	$12.50 per Prescription Order or Refill. Not subject to payment of the Annual Deductible.
Tier 3	$100 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$250 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$250 per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 4	40% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	40% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.
Tier 5	50% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	50% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	50% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.

SAMPLE

Pediatric Dental Care Services Schedule of Benefits

How do you Access Pediatric Dental Care Services?

Network Benefits

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

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

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

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

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

Payment Information

Benefits:

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

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

Annual Deductible

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

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

Schedule of Benefits Information Table

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Diagnostic Services - (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.* Periodic oral evaluation. Limited oral evaluation - problem focused.	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.**
Teledentistry - synchronous - real time encounter. Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. Comprehensive oral evaluation. Comprehensive periodontal evaluation. Detailed and extensive oral evaluation - problem focused.	
Intraoral Radiographs (X-ray) Limited to 1 series of films per 36 months. Intraoral - comprehensive series of radiographic images. Intraoral - comprehensive series of radiographic images - image capture only. Intraoral tomosynthesis - comprehensive series of radiographic images. Intraoral tomosyntheses – comprehensive series of radiographic images - image capture only.	None
The following services are limited to 2 per 12 months. Intraoral - periapical first radiographic image. Intraoral - periapical - each additional radiographic image. Intraoral - occlusal radiographic image. Intraoral tomosynthesis - periapical radiographic image. Intraoral tomosynthesis - periapical radiographic image - image capture only. Intraoral - occlusal radiographic image - image capture only. Intraoral - periapical radiographic image - image capture only.	None
Any combination of the following services is limited to 2 series of films per 12 months. Bitewing – single radiographic image. Bitewings – two radiographic images. Bitewings – four radiographic images. Vertical bitewings 7 to 8 radiographic images Intraoral tomosynthesis - comprehensive series of radiographic images.	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.**
Intraoral tomosynthesis - bitewing radiographic image - image capture only. Intraoral - bitewing radiographic image - image capture only.	
Limited to 1 time per 36 months. Panoramic radiograph image. Panoramic radiographic image - image capture only. 2-D Cephalometric radiographic image - image capture only.	None
The following services are limited to two images per calendar year. Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. 2-D Cephalometric radiographic image - acquisition, measurement and analysis. 2-D Oral/facial photographic images obtained intra-orally or extra-orally. Diagnostic casts. 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
The following service is limited to one time every six months: Dental Prophylaxis (Cleanings)	None
The following service is limited to one time every six months: Fluoride Treatments.	None
Sealants (Protective Coating) *The following services are* limited to once per first or second permanent molar every 36 months. Sealant - per tooth Preventive resin restorations in moderate to high caries risk patient - permanent 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.**
Space maintainer - fixed, unilateral - per quadrant. Space maintainer - fixed - bilateral maxillary. Space maintainer - fixed - bilateral mandibular. Space maintainer - removable, unilateral - per quadrant. Space maintainer - removable - bilateral maxillary. Space maintainer - removable - bilateral mandibular. Re-cement or re-bond bilateral space maintainer - maxillary. Re-cement or re-bond bilateral space maintainer - mandibular. Re-cement or re-bond unilateral space maintainer - per quadrant. Removal of fixed unilateral space maintainer - per quadrant. Removal of fixed bilateral space maintainer - maxillary. Removal of fixed bilateral space maintainer - mandibular. Distal shoe space maintainer - fixed - unilateral - per quadrant.	
Minor Restorative Services - (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Amalgams - one surface, primary or permanent. Amalgams - two surfaces, primary or permanent. Amalgams - three surfaces, primary or permanent. Amalgams - four or more surfaces, primary or permanent.	40%
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Resin-based composite - one surface, anterior.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Resin-based composite - two surfaces, anterior. Resin-based composite - three surfaces, anterior. Resin-based composite - four or more surfaces or involving incised angle, anterior.	
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)	
The following services are subject to a limit of one time every 60 months. Onlay - metallic - two surfaces. Onlay - metallic - three surfaces. Onlay - metallic – four or more surfaces. Crown - porcelain/ceramic. Crown - porcelain fused to high noble metal. Crown - porcelain fused to predominately base metal. Crown - porcelain fused to noble metal. Crown - porcelain fused to titanium and titanium alloys. Crown - 3/4 cast high noble metal. Crown - 3/4 cast predominately base metal. Crown - 3/4 porcelain/ceramic. Crown - full cast high noble metal. Crown - full cast predominately base metal. Crown - full cast noble metal. Crown - titanium and titanium alloys. Prefabricated stainless steel crown - primary tooth. Prefabricated stainless steel crown - permanent tooth. *The following services are not subject to a frequency limit.* Inlay - metallic - one surface. Inlay - metallic - two surfaces. Inlay - metallic - three surfaces. Re-cement or re-bond inlay. Re-cement or re-bond crown.	40%
The following service is not subject to a frequency limit. Protective restoration.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following service is limited to one time per tooth every 60 months. Prefabricated porcelain crown - primary. Core buildup, including any pins.	40%
Pin retention - per tooth, in addition to crown.	40%
The following service is *not subject to a frequency limit.* Prefabricated post and core in addition to crown.	40%
The following services are not subject to a frequency limit. Crown repair necessitated by restorative material failure. Inlay repair necessitated by restorative material failure. Onlay repair necessitated by restorative material failure. Veneer repair necessitated by restorative material failure	40%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Therapeutic pulpotomy (excluding final restoration). Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	40%
The following services are not subject to a frequency limit. Endodontic therapy, anterior tooth(excluding final restoration). Endodontic therapy, premolar tooth (excluding final restoration). Endodontic therapy, molar tooth (excluding final restoration). Retreatment of previous endodontic therapy - anterior.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Retreatment of previous endodontic therapy - bicuspid. Retreatment of previous endodontic therapy - molar.	
The following services are not subject to a frequency limit. Apexification/recalcification - initial visit. Apexification/recalcification/pupal regeneration - interim medication replacement. Apexification/recalcification - final visit.	40%
The following services are not subject to a frequency limit. Apicoectomy - anterior. Apicoectomy – premolar (first root). Apicoectomy – molar (first root). Apicoectomy - each additional root. Root amputation – per root. Surgical repair of root resorption - anterior. Surgical repair of root resorption - premolar. Surgical repair of root resorption - molar. Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	40%
The following service is not subject to a frequency limit. Hemisection (including any root removal), not including root canal therapy. Intraorifice barrier	40%
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 36 months. Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	
The following services are limited to one every 36 months. Gingival flap procedure, including root planning four or more contiguous teeth or tooth bounded spaces per quadrant. Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. Clinical crown lengthening – hard tissue.	40%
The following services are limited to one every 36 months. Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded teeth spaces per quadrant. Bone replacement graft – retained natural tooth first site in quadrant. Removal of non-resorbable barrier.	40%
The following service is not subject to a frequency limit. Pedicle soft tissue graft procedure.	40%
The following services are not subject to a frequency limit. Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft. Non-autogenous connective tissue graft first tooth implant. Free soft tissue graft procedure - first tooth. Free soft tissue graft procedure – each additional contiguous tooth. Splint - intra-coronal; natural teeth or prosthetic crowns. Splint - extra-coronal; natural teeth or prosthetic crowns.	40%
The following services are limited to one time per quadrant every 24 months. Periodontal scaling and root planing - four or more teeth per quadrant.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Periodontal scaling and root planing - one to three teeth per quadrant. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	
The following service is limited to a frequency of one per lifetime. Full mouth debridement to enable comprehensive evaluation and diagnosis.	40%
The following service is limited to 2 times every 12 months . Periodontal maintenance.	40%
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. Complete denture - maxillary. Complete denture - mandibular. Immediate denture - maxillary. Immediate denture - mandibular. Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth). - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth). Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	
The following services are not subject to a frequency limit. Adjust complete denture - maxillary. Adjust complete denture - mandibular. Adjust partial denture - maxillary. Adjust partial denture - mandibular. Repair broken complete denture base - mandibular. Repair broken complete denture base - maxillary. Replace missing or broken teeth - complete denture. Repair resin partial denture base - mandibular. Repair resin partial denture base - maxillary. Repair cast partial framework - mandibular. Repair cast partial framework - maxillary. Repair or replace broken retentive/clasping materials - per tooth. Replace broken teeth - per tooth. Add tooth to existing partial denture. Add clasp to existing partial denture.	40%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. Rebase complete maxillary denture.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Rebase complete mandibular denture. Rebase maxillary partial denture. Rebase mandibular partial denture. Rebase hybrid prosthesis. Reline complete maxillary denture (direct). Reline complete mandibular denture (direct). Reline maxillary partial denture (direct). Reline mandibular partial denture (direct). Reline complete maxillary denture (indirect). Reline complete mandibular denture (indirect). Reline maxillary partial denture (indirect). Reline mandibular partial denture (indirect). Add metal substructure to acrylic full denture (per arch).	
The following services are not subject to a frequency limit. Tissue conditioning (maxillary). Tissue conditioning (mandibular). Soft liner for complete or partial removable denture - indirect.	40%
Bridges (Fixed partial dentures) - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Pontic - cast high noble metal. Pontic - cast predominately base metal. Pontic - cast noble metal. Pontic - titanium and titanium alloys. Pontic - porcelain fused to high noble metal. Pontic - porcelain fused to predominately base metal. Pontic - porcelain fused to noble metal. Pontic - porcelain fused to titanium and titanium alloys. Pontic - porcelain/ceramic.	40%
The following services are not subject to a frequency limit. Retainer - cast metal for resin bonded fixed prosthesis. Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	40%

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 limited to one time every 60 months. Retainer crown - porcelain/ceramic. Retainer crown - porcelain fused to high noble metal. Retainer crown - porcelain fused to predominately base metal. Retainer crown - porcelain fused to noble metal. Retainer crown - porcelain fused to titanium and titanium alloys. Retainer crown - 3/4 cast high noble metal. Retainer crown - 3/4 cast predominately base metal. Retainer crown - 3/4 cast noble metal. Retainer crown - 3/4 porcelain/ceramic. Retainer crown - 3/4 titanium and titanium alloys. Retainer crown - full cast high noble metal. Retainer crown - full cast predominately base metal. Retainer crown - full cast noble metal.	40%
The following services are not subject to a frequency limit. Re-cement or re-bond fixed partial denture. Fixed partial denture repair necessitated by restorative material failure.	40%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Extraction, erupted tooth or exposed root. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Removal of impacted tooth - soft tissue. Removal of impacted tooth - partially bony. Removal of impacted tooth - completely bony. Removal of impacted tooth - completely bony with unusual surgical complications. Surgical removal or residual tooth roots. Coronectomy - intentional partial tooth removal.	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following service is not subject to a frequency limit. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	40%
The following service is not subject to a frequency limit. Surgical access of an unerupted tooth.	40%
The following services are not subject to a frequency limit. Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces per quadrant. Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant. Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	40%
The following service is not subject to a frequency limit. Removal of lateral exostosis (maxilla or mandible).	40%
The following services are not subject to a frequency limit. Incision and drainage of abscess. Marsupialization of odontogenic cyst. Suture of recent small wounds up to 5 cm. Bone replacement graft for ridge preservation - per site. Buccal/labial frenectomy (frenulectomy). Lingual frenectomy (frenulectomy). Excision of pericoronal gingiva.	40%
The following services are limited to one every 36 months. Guided tissue regeneration, edentulous area - resorbable barrier, per site. Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	40%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	

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 service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. Palliative (Emergency) treatment of dental pain - per visit.	40%
Covered only when clinically Necessary. Deep sedation/general anesthesia first 15 minutes. Deep sedation/general anesthesia each 15 minute increment. Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. Therapeutic parental drug single administration.	40%
Covered only when clinically Necessary. Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	40%
The following is limited to one guard every 12 months. Occlusal guard - hard appliance, full arch. Occlusal guard - soft appliance, full arch. Occlusal guard - hard appliance, partial arch.	40%
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. Surgical placement of implant body: Endosteal implant. Surgical placement of Eposteal implant. Surgical placement of Transosteal implant Implant supported complete denture. Implant supported partial denture. Connecting bar implant or abutment supported. Prefabricated abutment includes modification and placement. Custom fabricated abutment - includes placement. Abutment supported porcelain ceramic crown. Abutment supported porcelain fused to metal crown (high noble metal).	40%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Abutment supported porcelain fused to metal crown (predominately base metal crown). Abutment supported porcelain fused to metal crown (noble metal crown). Abutment supported cast high noble metal crown. Abutment supported cast predominately base metal crown. Abutment supported porcelain/ceramic crown. Implant supported porcelain/ceramic crown. Implant supported crown - porcelain fused to high noble alloys. Implant supported crown - high noble alloys. Abutment supported retainer for porcelain/ceramic fixed partial denture. Abutment supported retainer for porcelain fused to high noble metal fixed partial denture. Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture. Abutment supported retainer for porcelain fused to noble metal fixed partial denture. Abutment supported retainer for cast high noble metal fixed partial denture. Abutment supported retainer for predominately base metal fixed partial denture. Abutment supported retainer for cast metal fixed partial denture. Implant supported retainer for ceramic fixed partial denture. Implant supported retainer for FPD - porcelain fused to high noble alloys. Implant supported retainer for metal FPD - high noble alloys. Implant/abutment supported fixed partial denture for completely edentulous arch. Implant/abutment supported fixed partial denture for partially edentulous arch. Implant maintenance procedure. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.	

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.**
Implant supported crown - porcelain fused to predominantly base alloys. Implant supported crown - porcelain fused to noble alloys. Implant supported crown - porcelain fused to titanium and titanium alloys. Implant supported crown - predominantly base alloys. Implant supported crown - noble alloys. Implant supported crown - titanium and titanium alloys. Repair implant prosthesis. Replacement of semi - precision or precision attachment. Repair implant abutment. Remove broken implant retaining screw. Abutment supported crown - porcelain fused to titanium and titanium alloys. Implant supported retainer - porcelain fused to predominantly base alloys. Implant supported retainer for FPD - porcelain fused to noble alloys. Surgical removal of implant body Debridement peri-implant defect. Debridement and osseous peri-implant defect. Bone graft peri-implant defect. Bone graft implant replacement. Implant/abutment supported interim fixed denture for edentulous arch - mandibular. Implant/abutment supported interim fixed denture for edentulous arch - maxillary. Implant supported retainer - porcelain fused to titanium and titanium alloys. Implant supported retainer for metal FPD - predominantly base alloys. Implant supported retainer for metal FPD - noble alloys. Implant supported retainer for metal FPD - titanium and titanium alloys. Implant index. Semi-precision abutment - placement. Semi-precision attachment - placement.	

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.**
Abutment supported retainer - porcelain fused to titanium and titanium alloys.	
The following service is not subject to a frequency limit. Removal of implant body not requiring bone removal nor flap elevation Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	40%
The following services are limited to one every 36 months. Guided tissue regeneration – resorbable barrier, per implant Guided tissue regeneration – non-resorbable barrier, per implant	40%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome*, *Treacher-Collins Syndrome, Pierre-Robin Syndrome*, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.	
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. Limited orthodontic treatment of the primary dentition. Limited orthodontic treatment of the transitional dentition. Limited orthodontic treatment of the adolescent dentition. Comprehensive orthodontic treatment of the transitional dentition. Comprehensive orthodontic treatment of the adolescent dentition. Removable appliance therapy.	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.**
Fixed appliance therapy. Pre-orthodontic treatment visit. Periodic orthodontic treatment visit. Orthodontic retention. Removal of fixed orthodontic appliances for reasons other than completion of treatment. Repair of orthodontic appliance - maxillary. Repair of orthodontic appliance - mandibular. Re-cement or re-bond fixed retainer - maxillary. Re-cement or re-bond fixed retainer - mandibular. Repair of fixed retainer, includes reattachment - maxillary. Repair of fixed retainer, includes reattachment - mandibular.	

SAMPLE

Pediatric Vision Care Services Schedule of Benefits

How do you Access Pediatric Vision Care Services?

Network Benefits

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

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

Payment Information

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

Annual Deductible

Unless otherwise stated in the below *Schedule of Benefits*, Benefits for pediatric Vision Care Services provided under this section are subject to the Annual Deductible stated in the medical *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this section applies to the Annual Deductible stated in the medical *Schedule of Benefits.*

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

Schedule of Benefits Information Table

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

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		40% Subject to payment of the Annual Deductible.
• Bifocal		40% Subject to payment of the Annual Deductible.
• Trifocal		40% Subject to payment of the Annual Deductible.
• Lenticular		40% Subject to payment of the Annual Deductible.
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None

SAMPLE

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

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Low Vision Testing		None Not subject to payment of the Annual Deductible.
• Low Vision Therapy		25% Not subject to payment of the Annual Deductible.

SAMPLE

What Is the Policy?

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

This Policy includes:

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

Read your Policy carefully.

Can This Policy Change?

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

Other Information You Should Have

Important Cancellation Information: For important cancellation information, please refer to *Section 4: When Coverage Ends.*

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

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

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

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Introduction to Your Policy

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

Review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this Policy and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this Policy and any summaries provided to you, this Policy controls.

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

How Do You Contact Us?

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

SAMPLE

Your Responsibilities

Enrollment and Required Premiums

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

You may select any Network Primary Care Physician, who is located in the Network Area and is accepting new patients. You may choose a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider’s license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child under the age of 18.

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.

ONGOING SPECIALTY CARE:

If a covered person has a serious or chronic degenerative, disabling, or life-threatening disease or condition that, in the opinion of the Covered Person's Network Primary Care Physician, in consultation with a Network Specialist Physician, requires ongoing specialty care, the Covered Person may request:

- The selection of a Network Specialist Physician as the Covered Person's Primary Care Physician. The Network Specialist Physician:
  - Must have expertise in treating the serious or chronic degenerative, disabling, or life-threatening disease or condition.
  - Must agree to be responsible for and capable of providing and coordination the Covered Person's primary and specialty care.

The selection of a Network Specialist Physician as a Primary Care Physician must be made under a treatment plan coordinated by the Network Specialist Physician and the Covered Person or his or her designee, after notice to the Covered Person's original Primary Care Physician and must be approved by us.

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Obtain Prior Authorization

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

Pay Your Share

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

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Our Responsibilities

Determine Benefits

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

We will determine the following:

- Interpret Benefits under this Policy, including by comparing the cost effectiveness of alternatives services or supplies when determining which of the services or supplies will be covered.
    - Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Amendments.
    - Make factual determinations relating to Benefits.

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

Disclosure of Payment Obligations

Note: Your actual expense for Covered Health Care Services may exceed the stated Co-insurance percentage or Co-payment amount because actual provider charges may not be used to determine our and your payment obligations.

For Co-payment amounts based off a percentage (rather than a flat dollar Co-payment), we calculate the Co-payment amount as follows:

For Network Providers:

Step 1: We determine the contracted rate we have with the provider for the care you receive.

Step 2: We then calculate your Co-payment on the contracted rate.

Step 3: Finally, we calculate our reimbursement to the provider by subtracting your Co-payment amount from the contracted rate. For information about how we determine calculated rate, please see Section 8: Defined Terms for a complete definition of Allowed Amount.

Example:

Deductible has been satisfied

Outpatient Surgery charge is $1,200

Contracted rate is $900

Co-insurance is 20%

You pay 20% of $900 =$180

We pay $900 - $180 = $720

For Out-of-Network Providers, Non-Medical Emergency or Not Coordinated by Us:

Step 1: We determine Allowed Amount for the care you received. We determine Allowed Amount using internal payment policy guidelines and available data resources. Please see Section 8: Defined Terms for a complete definition of Allowed Amount.

Step 2: We then calculate your Co-payment on Allowed Amount. Note: Your actual expenses for Covered Health Care Services may exceed the stated Co-payment amount because actual provider charges may not be used to determine our and your payment obligations.

Step 3: We calculate our payment by subtracting your Co-payment amount from the Allowed Amount.

Step 4: We determine if there is any remaining balance resulting from the difference between the actual provider charges and the Allowed Amount. You are responsible for paying 100% of the difference between the actual billed charges and Allowed Amount for your care.

Example:

SAMPLE

Actual Outpatient Surgery charge is $1,500; Deductible has been satisfied.

Allowed Amount - $1,200

Co-insurance is 20% of $1,200 (Allowed Amount) =$240

We pay $1,200 (Allowed Amount) - $240 (Co-payment) =$960

You pay the difference between the actual charges and Allowed Amount and your Co-payment amount:

$1,500 - $1,200 = $300 plus $240 = $540

For Out-of-Network Providers, Emergency Medical Condition or Otherwise Coordinated by Us:

Step 1: We work with the provider to obtain a negotiated rate.gl

Step 2:

- If a negotiated rate is obtained, we calculate your Co-payment based on the negotiated rate.
- If a negotiated rate is not obtained, we calculate your Co-payment based on the provider's actual billed charges or the Allowed Amount for an Emergency Medical Condition.

Step 3:

- If a negotiated rate is obtained, we calculate our payment by subtracting your Co-payment amount from the negotiated rate.
- If a negotiated rate is not obtained, we calculate our payment by subtracting your Co-payment amount from the provider's actual charges or the Allowed Amount for an Emergency Medical Condition.

Examples:

Actual Outpatient Surgery charge is $1,500; Deductible has been satisfied.

1. *Negotiated Rate = $1,200*

   Co-insurance is 20%

   You pay $240

   We pay $1,200 (negotiated rate) - $240 (Co-payment) = $960

2. *Non-Negotiated Rate = $1,500*

   Co-insurance is 20%

   You pay $300

   We pay $1,500 (non-negotiated rate) - $300 (Co-payment) = $1,200

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*.

SAMPLE

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Review and Determine Benefits in Accordance with Generally Accepted Standards of Medical Practice

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.

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.

SAMPLE

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

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

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

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

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

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

Essential Health Benefits are provided without any lifetime dollar limit or annual dollar limit applicable to the Benefit categories set forth below. Essential Health Benefits are subject to other types of limits as set forth below or as set forth in the Policy, Schedule of Benefits and any applicable Amendments.

The following Benefits are Essential Health Benefits and are not provided as part of any state mandate:

- Physician’s Office Services - Sickness and Injury
- Surgery - Outpatient
- Hospice Services
- Infertility Services (related to treatment of underlying cause of infertility)
- Private Duty Nursing
- Urgent Care Center Services
- Home Health Care
- Ambulance Services
- Physician’s Fees for Surgical and Medical Services
- Obesity Surgery
- Skilled Nursing Facility
- Pregnancy

SAMPLE

- Mental Health Care Services
- Substance-Related and Addictive Disorder Services
- Pharmaceutical Products - Outpatient
- Rehabilitation Services - Outpatient Therapy and Manipulative Treatment
- Habilitation Services
- Durable Medical Equipment (DME), Orthotics and Supplies
- Ostomy Supplies
- Pediatric Vision Care Services
- Pediatric Dental Care Services
- Preventive and Well Baby Care Covered at 100%
- Lab, X-Ray and Diagnostics - Outpatient
- Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient
- Transplantation Services
- Dental Services - Accident Only
- Therapeutic Treatments - Outpatient
- Prosthetic Devices
- Nutritional Counseling
- Sterilization
- Blood Services
- Anesthesia
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Orthotics for Position Plagiocephaly
- Organ Donor Search
- Sexual Dysfunction (related to organic disease only)

In addition, the following Benefits are provided according to state mandates:

- Outpatient Facility Fees
- Emergency Health Care Services - Outpatient
- Hospital - Inpatient Stay
- Non-Preferred Brand Drugs
- Hearing Aids
- Preventive Care/Screening/Immunization Services
- Diabetes Education
- Diabetes Care Management
- Temporomandibular Joint Services
- Reconstructive Procedures
- Clinical Trials
- Off Label Prescription Drugs
- Dental - Anesthesia and Hospital or Facility Charges
- Congenital Anomaly

SAMPLE

- Lymphedema Services
- Autism Spectrum Disorder Services

Ambulance Services

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

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

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

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

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

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.

SAMPLE

- 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.
- 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.

Covered Clinical Trials must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

The drug, however, must be approved by the FDA and must have been proven effective and accepted for treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- The National Comprehensive Cancer Network Drugs & Biologics Compendium.

SAMPLE

- The Thomson Micromedex DrugDex.
- The Elsevier Gold Standard's Clinical Pharmacology.
- Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Dental Anesthesia

Anesthesia and Hospital or facility charges in connection with dental procedures when hospitalization or general anesthesia is required.

Persons eligible for this benefit include:

- Children below the age of nine years.
- Person with serious mental or physical condition.
- Persons with significant behavioral problems.

Your dentist must certify (or provide supporting documentation) that the criteria have been met.

Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within -24 months of the accident, or if not a Covered Person at the time of the accident, within the first -24 months of coverage under the Policy.

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

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

Diabetes Services

Diabetes Self-Management and Training and Education Services

SAMPLE

"Diabetes self-management training and educational services" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. The instruction should be provided in accordance with a program in compliance with the *National Standards of Diabetes Self-Management Education Program* as developed by the *American Diabetes Association*. Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a health care professional and when provided by a certified, registered or licensed health care professional. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care and diabetic specific foot orthotics, orthopedic shoes, inserts, modifications, and footwear when Medically Necessary for the treatment of complications related to diabetes.

Diabetic Self-Management Supplies

Benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and glucose tablets, single measurement glucose monitors, including those for the legally blind, certain insulin pumps and certain continuous glucose monitors as described under the *Outpatient Prescription Drugs* section. Certain continuous glucose monitors and ~~certain~~ insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME)*.

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

Durable Medical Equipment (DME)

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

DME includes, but isn't limited to:

- Canes.
- Commode chairs.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- External components of, and batteries for, cochlear implants and other implantable hearing devices.
- Hospital beds.
- Infusion pumps.
- Nebulizers.

Ostomy supplies are covered and limited to the following:

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

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

- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.

SAMPLE

- Suction pumps.
- Traction equipment.
- Walkers.
- Wheelchairs.

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

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

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

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

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

Emergency Health Care Services - Outpatient

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

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

Enteral Nutrition

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

Eyeglasses for Disease or Injury

Benefits include a one-time replacement of eyeglasses or contact lenses when required as a result of a prescription change after cataract surgery.

Gender Dysphoria

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

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

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or Maintenance Program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. 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.

SAMPLE

- 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:

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

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

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

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

Hearing Aids

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

Benefits are available for all Medically Necessary Hearing Aids and services that are ordered by a Physician or an Audiologist licensed in North Carolina. Benefits are provided for the Hearing Aid and for charges for associated fitting and testing. Services include the initial Hearing Aid evaluation, fitting, adjustments, and supplies, including ear molds.

Initial Hearing Aids and replacement Hearing Aids are covered for enrolled members not more frequently than every 36 months. New hearing aids are covered when alterations to the existing Hearing Aid cannot adequately meet the needs of the Covered Person.

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

SAMPLE

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

Cochlear implants are not Hearing Aids. Benefits do not include bone anchored Hearing Aids. Bone anchored Hearing Aids are a Covered Health Care Service for which Benefits are available under 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.

Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by a home health aide, home health therapist or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health Care.
- Home infusion therapy:
  - Includes the administration of a prescription drug directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous, or epidural routes.
  - Under a plan prescribed by a doctor and provided by or under the supervision of a registered nurse or licensed practical nurse.

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

Private Duty Nursing

Benefits for Private Duty Nursing services provided in the home through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. These Private Duty Nursing services will be provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for a covered person who needs more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health care agency. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

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.

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

Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

SAMPLE

- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
  - One routine prostate specific antigen (PSA) test, or an equivalent serological test per calendar year, and for additional PSA tests, if recommended by a Physician.
  - Ovarian cancer surveillance tests for women age 25 and older who are at risk for ovarian cancer. For purposes of this Benefit, the following definitions apply:

  "Surveillance Tests" means annual screening using:

  - Rectovaginal ultrasound.
  - Transvaginal ultrasound.

  "At Risk for Ovarian Cancer" means:

  - Having a family history.
  - With at least one first degree relative with ovarian cancer.
  - A second relative, either first degree or second degree, with breast, ovarian, or nonpolyposis colorectal cancer.
  - Testing positive for a hereditary ovarian cancer syndrome.

  - When Medically Necessary, benefits for a follow up bone mass measurement will be provided more frequently than every 23 months as a Covered Health Care Service for which benefits are available under the applicable medical/surgical Covered Health Care Service categories in this Policy.
  - Medically Necessary conditions include but are not limited to:
  - Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.
  - Central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual with proven low bone mass, provided the measurement is performed 12 to 18 months from the start date of the additional regiment.

  Bone mass measurements are covered under the Preventive Care Services section of this Policy for qualified individuals being screened.

  - Cervical cancer screening for the early detection of cervical cancer in accordance with the most recent published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control including:

  - Pap smears.
  - Liquid-based cytology.

SAMPLE

- Human papilloma virus (HPV) detection method for woman with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

Cervical cancer tests recommended by USPSTF and HRSA are covered under the Preventive Care Services section of this Policy.

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*.

Lymphedema Services

Benefits for the diagnosis, evaluation and treatment of lymphedema include Benefits for equipment and supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

Note that gradient compression garments for this treatment:

- Require a prescription.
- Are custom-fit for the Covered Person.
- Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

Manipulative Treatments

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

For Habilitative Manipulative Treatment, services must help you keep or improve skills and functioning for daily living. This includes services for people with disabilities in an inpatient or outpatient setting.

For Rehabilitative Manipulative Treatment, services must involve goals you can reach in a reasonable period of time. Benefits will end when progress toward the goal ends.

Benefits are limited as described in the *Schedule of Benefits*.

Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.

SAMPLE

- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Program.
- 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.
- Biofeedback.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA)) that are both of the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a Board-Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.

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

Morbid Obesity Surgery

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

Necessary Medical Supplies

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

Orthotics

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

Orthotic braces, including needed changes to shoes to fit braces, braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service. This includes orthotic devices for the correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets.

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

Pharmaceutical Products - Outpatient

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

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

SAMPLE

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

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

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.

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.
- Certain services related to the diagnosis, treatment, and correction of any underlying causes of Sexual Dysfunction for all covered Persons. Benefits will be provided under the corresponding Benefit category in this Policy.
- Diagnosis, treatment and correction of the underlying causes of infertility. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.
- Allergy testing and injections.
- Medical nutrition therapy provided by a licensed dietician or nutritionist, working in coordination with a Physician, to treat a chronic illness or condition.

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

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

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

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Complications of Pregnancy include conditions that require treatment during a Pregnancy or during the post-partum period. Benefits include those of a certified nurse-midwife.

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.

SAMPLE

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.

Please note: Prior authorization is not required for the minimum Hospital Inpatient Stay following childbirth. Your newborn may have other valid primary coverage that covers the 48 hours of inpatient stay following a normal vaginal delivery or 96 hours of inpatient stay following a cesarean section.

Post Delivery Follow-up Care

In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, we will provide coverage for timely post-delivery care within 72 hours of discharge, pursuant to NCGS 58-3-169(d) and (e). Covered Health Care Services will be provided to a mother and her newborn child by a registered nurse, Physician, nurse practitioner, nurse midwife, or Physician assistant experienced in maternal and child health in:

- The home, a provider's office, a Hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a state health department maternity clinic.
- Another setting determined appropriate under federal regulations promulgated under *Title VI* of *Public Law 104-204.*

The attending Physician in consultation with the mother shall decide the most appropriate location for follow-up care.

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.* Benefits for colorectal cancer screenings that do not have in effect a rating of “A” or “B” are described under *Scopic Procedures – Outpatient Diagnostic and Therapeutic*, including coverage for colorectal cancer examination and laboratory tests for cancer.
- 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.* Contraceptive devices, including the insertion or removal of, and any Medically Necessary consultations, examinations, or procedures associated with, the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives. Benefits include voluntary female sterilization and associated anesthesia.

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

Benefits include:

- Bone mass measurements. Benefits for bone mass measurement will be provided for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. A second bone mass measurement may be provided if at least 23 months has elapsed since the last bone mass measurement was performed.

SAMPLE

- Mammography screening. Benefits for screening mammography include:
  - One or more mammograms a year, as recommended by a Physician for any woman who is at risk for breast cancer.
  - One baseline mammogram age 35 - 39 years of age.
  - A mammogram every other year for age 40 - 49 years of age.
  - A mammogram every year for age 50 or older.
- Newborn hearing screening ordered by the attending Physician.

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.

Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition.

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 requirements for your needs. If you purchase a prosthetic device that exceeds these minimum requirements, we will pay only the amount that we would have paid for the prosthetic that meets the minimum requirements. You will be responsible for paying any difference in cost.

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

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

Reconstructive Procedures

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

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

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

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

Please note that Benefits for breast surgery following a mastectomy include coverage for all stages and revisions of reconstructive breast surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and lymphedema stockings, physical complications, including lymphedema, in all stages of mastectomy. Reconstruction of the nipple/areola complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating Physician. Coverage includes post-mastectomy inpatient care. The decision regarding discharge following surgery is made by the attending Physician in consultation with the patient, and will ensure that the length of post-mastectomy Hospital stay is based on the unique characteristics of each patient, taking into consideration the health and medical history of the Covered Person.

SAMPLE

Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, such as lymphedemas during all stages of a mastectomy, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

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

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

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

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

Benefits are not available for maintenance/preventive treatment.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

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

Benefits include:

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

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

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).

SAMPLE

- 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.

Surgery - Outpatient

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

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

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services including the professional fees of your surgeon are described under *Physician Fees for Surgical and Medical Services*.)
- Voluntary male sterilization and associated anesthesia.
- Cataract surgery with a standard intraocular lens.
- Surgical implantation of cochlear implants or other implantable hearing devices when you have either of the following:
  - Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable Hearing Aid.
  - A diagnosis of Sensorineural Hearing Loss, or SNHL, where there is no damage to the inner ear or to the nerve pathways from the inner ear to the brain.

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

Telehealth

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

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

SAMPLE

Temporomandibular Joint Syndrome (TMJ)

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

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

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

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

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

Therapeutic Treatments - Outpatient

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

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous Chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals.

Benefits include:

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

Blood

Covered Health Care Services include transfusions of blood, plasma, blood plasma expanders, and other fluids injected into the bloodstream. The cost of storing a Covered Person's own blood will be a Covered Health Care Service only when it is stored and used for a previously scheduled procedure.

Transplantation Services

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

Examples of transplants for which Benefits are available include:

- Bone marrow/stem cell.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.

SAMPLE

- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

Benefits include:

- Donor and organ search; and
- Transportation and lodging.

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

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

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

Urgent Care Center Services

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

Virtual Care Services

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

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

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

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

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

SAMPLE

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

Alternative Treatments

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

Dental

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

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

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

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

SAMPLE

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Diabetes Services, Durable Medical Equipment (DME),* and *Orthotics* in *Section 1: Covered Health Care Services.*
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
   - Transport chairs. Examples of transport chairs include:
     - Powered walker including enhancement accessories of walkers.
     - Combination wheeled walker with seat and transport chair.
4. Devices and computers to help in communication and speech.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Wigs.

SAMPLE

Drugs

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

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

Experimental or Investigational Services

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

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

Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.

SAMPLE

- 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. Foot orthotics, orthopedic shoes, inserts, modifications, and footwear except as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies.

   Examples of supplies that are excluded include:

   - Ace bandages.
   - Gauze and dressings.
   - Items routinely found in the home.

   This exclusion does not apply to:

   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME)* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services* and in *Outpatient Prescription Drugs*.
   - Compression stockings. This does not apply to diabetic supplies or compression garments as described under *Lymphedema Services* in *Section 1: Covered Health Care Services.*
2. Tubings except when used with DME as described under *Durable Medical Equipment (DME)* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Nutrition

1. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*
2. Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.
3. Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as listed in the benefit plan.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.

SAMPLE

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 changes such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Safety equipment.
    - Treadmills.
    - Vehicle changes such as van lifts.
    - Video players.
    - Whirlpools.

Physical Appearance

1. Cosmetic Procedures when not determined to be Medically Necessary. See the definition in *Section 8: Defined Terms*. Examples include:
    - Membership costs and fees for health clubs and gyms. This exclusion does not apply to incentives provided as described under the heading *Are Incentives Available to You?* In *Section 7: General Legal Provisions*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

SAMPLE

- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of veins.
- Hair removal or replacement by any means.
- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

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

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Medically Necessary panniculectomy.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.

SAMPLE

6. Biofeedback, except as described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.*

7. The following services for the diagnosis and treatment of Temporomandibular Joint Syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.

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

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 change techniques and medications to control cravings.

10. Breast reduction and augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

11. Helicobacter pylori *(H. pylori)* serologic testing.

12. Intracellular micronutrient testing.

13. Obesity - weight loss surgery not received at a Designated Provider.

14. Sex transformation surgery, including medical and hormonal therapy in preparation for and subsequent to any such surgery is excluded.

Providers

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

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

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

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

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services performed for the diagnosis, treatment and correction of any underlying cause of infertility as described under *Physician's Office Services – Sickness and Injury* in *Section 1: Covered Health Care Services.* Covered benefits for outpatient prescription drugs are limited to 3 medical ovulation induction cycles per lifetime per covered person.

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

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

SAMPLE

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

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

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

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). This exclusion does not apply to termination of pregnancy when the life of the mother would be endangered if the fetus were carried to term or the pregnancy is the result of rape or incest.

Services Provided under another Plan

1. Health services and supplies for the treatment of an occupational Injury or Sickness which are paid under the *North Carolina Workers' Compensation Act* only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the *North Carolina Workers' Compensation Act* or an order of the *North Carolina Industrial Commission* approving a settlement agreement under the *North Carolina Workers' Compensation Act*.
2. 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.
3. Health care services during active military duty.

Transplants

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

Travel

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

Types of Care, Supportive Services and Housing

1. Custodial Care or maintenance care.
2. Domiciliary care.

SAMPLE

3. 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*.
4. Rest cures.
5. Services of personal care aides.
6. Independent living services.
7. Assisted living services
8. Educational counseling, testing and support services including tutoring, mentoring, tuition and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act.*
9. 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).
10. Transitional Living services (including recovery residences).

Unproven Services

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

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses, except as covered under *Eyeglasses for Disease or Injury* in Section 1: *Covered Health Services* and as covered under *Section 11: Pediatric Vision Care Services.* This exclusion does not apply to contact lenses or scleral shells that are used to therapeutically treat injury or disease (such as corneal abrasion, keratoconus or severe dry eye).
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to Benefits provided through *Section 11. Pediatric Vision Care Services.*
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Over-the-counter Hearing Aids.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Policy* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under this *Policy* when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or services, incidental to adoption, which are required prior to placement for adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.

SAMPLE

- 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. This exclusion does not apply to continuity of care as described under the continuity of care provision in *Section 4: When Coverage Ends*.
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.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation, except for Emergency Health Care Services and services outside the provider Network when no care is available from a Network provider.
8. Long-term storage:
   - Long-term storage services are not a Covered Health Care Service.
   - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a member is entering the military, etc., we will not cover any long-term storage of the above.
   - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
9. Autopsy, except when the autopsy is done at our request.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

SAMPLE

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Federal Health Insurance Marketplace, available at HealthCare.gov. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

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

Eligible Person

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

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

Dependent

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

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

When Do You Enroll and When Does Coverage Begin?

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

Open Enrollment Period

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

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

Special Enrollment Period

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

Adding New Dependents

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

SAMPLE

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

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

Subject to a determination of the Federal Health Insurance Marketplace, an eligible child legally placed with you or your spouse for adoption or foster care or by court or administrative order will be covered from the date of placement until the 31st day after placement, unless the legal obligation is terminated and the child is removed from your or your spouse's custody.

A child placed for adoption or foster care or by court or administrative order prior to the age of 18 years will be covered for loss due to Sickness or Injury, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Enrollment information from the Federal Health Insurance Marketplace will be required to continue coverage beyond the 31st day following placement of the child. You must notify the Federal Health Insurance Marketplace of the child's placement for adoption or foster care or by court or administrative order. The effective date of the child's coverage will follow the rules of the federal Health Insurance Marketplace. Any additional premium necessary will be calculated from the date determined by the Federal Health Insurance Marketplace.

If additional premium is required, coverage of the child will terminate on the 31st day following placement, unless we have received both written notice of the child's placement and any additional premium required within 90 days of the date of placement.

As used in this provision, "placement" means the earlier of:

A. The date that you or your spouse assume physical custody of the child for the purpose of adoption or foster care.

B. The date of entry of an or by court or administrative order granting you or your spouse custody of the child for the purpose of adoption or foster care, or otherwise.

The Enrollment period is waived when a parent is required to enroll a child due to an administrative or court order.

Premiums

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

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

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

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

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

If Premium payments are not made as required:

- Your coverage will end as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.
- In order to enroll in a new plan after terminating for non-payment, as allowed under federal law, we may require that your re-enrollment be subject to:

SAMPLE

- Your payment in full of any past due premiums owed to us within the last 12 months.
- Payment of the first month's premium for the new plan.

Misstatement of Age or Tobacco Use

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

Change or Misstatement of Residence

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

Grace Period

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

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

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

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

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 45 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 policies for the reasons explained in this *Policy*. Notice of termination of this *Policy*, including the reason, will be provided to you at least 90 days prior to the date of termination.

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

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

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

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

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

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- The date determined by the Federal Health Insurance Marketplace that this Policy will terminate because the Policyholder no longer lives in the Service Area.
- The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

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

SAMPLE

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*. After two years from the date of issue or reinstatement of this *Policy*, no misstatement, except fraudulent misstatement made by the applicant in the application for such *Policy,* shall be used to void the *Policy* or deny a claim for loss incurred or disability (as defined in the *Policy*) commencing after the expiration of such two-year period.

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.

Continuity of Care

This continuity of care provision applies to you if either of the following is true:

- You have an ongoing special condition and the Network provider from whom you are receiving care loses his/her status as a Network provider and becomes an Out-of-Network Provider (for reasons other than those relating to quality of care or fraud). We will notify you on a timely basis that the provider is no longer a Network provider and of your right to elect continuation of coverage with that provider.
- You are newly a Covered Person because your employer has changed health benefit plans and you have an ongoing special condition for which you are receiving treatment from an Out-of-Network Provider. We will notify you on the date of enrollment of the right to elect continuation of coverage with that provider.

Your right to continue treatment for an ongoing special condition from the Out-of-Network Provider will be valid for a transitional period of time as follows:

- In general, you will have up to 90 days from the date of notice that such provider is no longer a Network provider, to continue treatment with your provider before benefits will end.
- For surgery, organ transplant, or inpatient care that was schedule before you received notice that such provider is no longer a Network provider, or if you were on an established waiting list, the transitional period shall extend

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through the date of discharge. In addition, coverage with that provider shall include post discharge follow-up care related to the surgery, transplantation, or other inpatient care happening within 90 days after the date of discharge.

- For Pregnancy, if you have entered the second trimester of pregnancy on the date of notice that such provider is no longer a Network provider, you will have benefits with that provider through treatment of the pregnancy, which shall include 60 days of postpartum care.

For a terminal illness, if the Covered Person is determined to be terminally ill at the time of a provider's termination as a Network provider, and the provider was treating the terminal illness before the date of the termination or enrollment in the new plan, the transitional period shall extend for the remainder of the Covered Person's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

Reinstatement

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

Certification of Coverage Form

As required by the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce a certificate of creditable coverage form for Covered Persons who lose coverage under this Policy on or after the effective date of this Policy. A certification of prior creditable coverage is a written certification of your period of creditable coverage, and any waiting period and affiliation period, if applicable to you.

We will provide a certification of prior creditable coverage when your coverage ends for any of the following reasons:

- At the time you cease to be covered under this Policy.
- Upon request on your behalf when the request is made not later than 24 months after the date coverage ends.

"Creditable coverage" means coverage under any of the following:

- A group health plan.
- Health insurance coverage in the group market or individual market.
- Part A or part B of *Title XVIII of the Social Security Act.*
- *Title XIX* of the *Social Security Act* (other than coverage consisting solely of benefits under *section 1928*.
- *Chapter 55* of *Title 10* of the *United States Code*.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under *Chapter 89* of *Title 5* of the *United States Code*.
- A public health plan (as defined in federal regulations).
- A health benefit plan under *section 5(e)* of the *Peace Corps Act*.
- *Title XXI* of the *Social Security Act (State Children's Health Insurance Program)*.
- Short-term limited duration health insurance coverage.

Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

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

Notice of Claim

You should submit a request for payment of Benefits within 180 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms and Proof of Loss

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

Required Information

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

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

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

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

OptumRx Claims Department,

PO Box 650540

Dallas, TX 75265-0540

Payment of Claims

Time for Payment of Claim

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

Assignment of Benefits

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

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

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

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

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

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Section 6: Questions, Complaints and Appeals

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

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

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

To send your letter to us, our address is:

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

What if You Have a Question?

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

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

What if You Have a Complaint?

A complaint is an expression of dissatisfaction.

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

We will notify you of our decision regarding your complaint within 30 business days of receiving it.

If the grievance concerns the quality of care you have received from your Physician, we will notify you within 10 business days that the complaint has been referred to the quality improvement department/committee for review and consideration. State law does not allow second-level complaint review for complaints concerning quality of care.

How Do You Appeal a Decision?

Grievance and Appeal Procedure

The appeal and grievance procedures described below are voluntary and ensure that you have the opportunity for appropriate resolution of any grievance or any noncertification of requested health services. This section provides you with information to help you with the following:

- Utilization review process.
- Appeals of non-certifications.
- Grievance Review Process.

Utilization Review Process

The use of utilization review methods ensures that you receive appropriate health care services in an appropriate setting. Utilization review includes a set of formal techniques designed to monitor the use of or evaluate the medical necessity, medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities.

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Utilization Review Program Operation

We use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to ensure ongoing efficacy. Qualified health care professionals administer the utilization review program under the direction of a medical director. A medical doctor licensed to practice medicine in North Carolina evaluates the clinical appropriateness of non-certifications.

In issuing utilization review decisions, we will obtain all information required to make the decision, including pertinent clinical information; ensure that utilization reviewers apply clinical review criteria consistently; and, issue timely decisions in accordance with applicable law. We will limit requests for information to only that information that is necessary to certify the service in question and will provide notification of utilization review decisions consistent with applicable law.

We may not certify an admission or service if you or your Physician are unable to provide, or fail to release, necessary information in a timely manner. Whenever prior certification is required in order to receive requested services, utilization review staff may be contacted by you and/or your Physician at the phone number listed on your ID Card.

Urgent Care Review

"Urgent care review" is review of any claim for health care services or treatment where the application of the time period for making a non-urgent care determination could either seriously jeopardize your life or health, or, in the opinion of a Physician with knowledge of your medical condition would subject you to severe pain that cannot be managed without treatment.

The initial urgent care review will be made as soon as possible but no later than 72 hours after receipt of the request. If additional information is needed:

- Within 24 hours of receipt of claim, we must make the request for additional information.
- You will have 48 hours from receipt of our request to supply the information.

We will make the determination within 48 hours of receiving the additional information or within 48 hours of the expiration of the time allowed to submit the additional information, whichever happens sooner.

Prospective (Pre-service) and Concurrent Reviews

"Prospective review" is utilization review conducted before an admission or course of treatment, including any required pre-authorization or pre-certification. "Pre-service" is a service that has not yet been obtained. "Concurrent review" is utilization review conducted during a patient's Hospital Inpatient Stay or course of treatment.

Prospective and concurrent review determinations will be communicated to your Physician within 3 business days after all necessary information about the admission, procedure, or health care services has been obtained. "Necessary Information" includes the results of any patient examination, clinical evaluation or second opinion that may be required. If additional information is needed, a request will be made within 3 business days of the original receipt of claim.

- You will have 45 calendar days from receipt of request to supply this information.
- A determination will be made and you and your Physician will be notified within 3 business days after receipt of the additional information.

In concurrent review situations, requests for extension of treatment involving urgent care will be decided within 24 hours of receipt of request provided that request is received within at least 24 hours prior to the expiration of prescribed treatment or treatment in progress. If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting hospital or other facility, a decision will be made and communicated as soon as possible, but no later than 72 hours after we receive the request. If we need more information to process the Member’s urgent review, we will notify the requesting hospital or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting hospital or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. We will make a decision within 48 hours of the earlier either the receipt of the requested information, or the end of the time period given to the requesting hospital or other facility to provide the information.

Your Physician will be notified when health care services are certified or non-certified. When services are non-certified, a written confirmation will be sent to you electronically or via U.S. mail. In concurrent reviews, we will remain liable for health care services until you have been notified of the noncertification.

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Retrospective (Post - Service) Reviews

"Retrospective review" means utilization review of Medically Necessary services and supplies that are conducted after services have been provided to the patient. It does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

For retrospective review determinations, a determination will be made within 30 calendar days of receipt unless additional information is needed to make the determination. If additional information is needed:

- Within 30 calendar days of original receipt of claim, we must make the request for additional information.
- You will have 90 calendar days from receipt of the request to supply this information.
- A determination will be made at the earlier of either:
  - 30 calendar days after the information is received.
  - 30 calendar days from the expiration of the time, you were allowed to submit additional information.

If additional information is submitted, you and your Physician will be notified within 30 calendar days of the receipt of this additional information. You, your authorized representative, if applicable, and your Physician will be notified when health care services are certified or when services are noncertified. For a noncertification, we will give written notification to you and your provider within 5 business days after making the noncertification.

Appeal and Grievance Procedures

You have certain appeal and grievance rights under the laws of North Carolina and the *United States Department of Labor.* As described below, you have the right to appeal an adverse benefit determination.

In the case of Appeals of non-certifications:

- A non-certification appeal is an internal appeal of clinical determination.
- There is one level of appeal available through us.
- You may also be entitled to request an independent external review through the *NCDO*I as explained below.

In case of a Grievance Review:

- There are two levels of internal review available through UnitedHealthcare.
- Independent external review through the NCDOI is not available for grievance reviews.

Your request for an appeal or grievance review should include:

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

If you need further assistance, you can contact Heath Insurance Smart NC or NCDOI at the information below.

Health Insurance Smart NC provides consumers with information and counseling on appeal issues, claim denials, and external review requests. You may contact this program at:

Mailing Address:

NC Department of Insurance

Health Insurance Smart NC

1201 Mail Service Center

Raleigh, NC 27699-1201

Telephone: (855) 408-1212

Fax: (919) 807-6865

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Website: https://www.ncdoi.gov/contactscomplaints/contact-ncdoi

Physical Address: NC Department of Insurance

3200 Beechleaf Court

Raleigh, NC 27604

The North Carolina Department of Insurance (NCDOI) is available to assist you with insurance-related questions and complaints. Inquiries may be directed in writing to NCDOI at:

Mailing Address: NC Department of Insurance

Health Insurance Smart NC

1201 Mail Service Center

Raleigh, NC 27699-1201

Telephone: (855) 408-1212

Fax: (919) 807-6865

Online: https://ncdoi.gov/assistance-or-file-complaint

Appeals of Non-certifications

You, or your authorized representative or Physician authorized to act on your behalf, have 180 calendar days from the date of the non-certification to appeal noncertification determinations. Noncertification determinations include Prescription Drug Product determinations as described under the Outpatient Prescription Drugs section of this Policy.

The appeal will be evaluated by a North Carolina licensed medical doctor who was not involved in the initial noncertification decision. As described below, non-certification appeals may be expedited under certain circumstances.

Standard Non-certification Appeals

- Within 3 business days after receiving a request for a standard, non-expedited appeal, you will be provided with the name, address, and telephone number of our authorized representative and information on how to submit written material.
- Within 30 calendar days after receiving the noncertification appeal request, we will issue a written notice, in clear terms, of the decision to you and your Physician.

Expedited Noncertification Appeals

- An expedited review process is available to address those situations where the standard appeal time frames would reasonably appear to seriously jeopardize life or health or jeopardize the ability to regain maximum function. Appeal requests involving urgent care may be submitted orally or in writing. Documentation will be required of the medical justification for the expedited appeal.
- We will issue a written notice, in clear terms, to the provider and to you no later than 72 hours after receiving the information justifying an expedited review. If additional information is needed:
  - Within 24 hours of receipt of claim, we may request additional information.
  - You will have 48 hours from receipt of the request to supply this information.
  - A determination will be made at the earlier of either:
    - 48 hours after information is received; or
    - 48 hours from expiration of the time you were allowed to submit the additional information.

As explained below, if you are dissatisfied with the non-certification appeal decision, you may be entitled to request an external review through the *NCDOI*.

External Review

North Carolina law provides for review of non-certification decisions by an external, independent review organization (IRO). The *North Carolina Department of Insurance (NCDOI)* administers this service at no charge to you, arranging for an IRO to review your case once the *NCDOI* establishes that your request is complete and eligible for review. You

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or your authorized representative may request an external review. We will notify you in writing of your right to request an external review each time you:

- Receive a non-certification decision, or
- Receive an appeal decision upholding a non-certification decision.

You or your authorized representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your authorized representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

In order for your request to be eligible for external review, the *NCDOI* must determine the following:

- That your request is about a medical necessity determination that resulted in a non-certification decision, or a determination of whether services are subject to balance billing protections or the cost-sharing applicable to such services.
- That you had coverage with us in effect when the non-certification decision was issued.
- That the service for which the non-certification was issued appears to be a service under your Policy.
- That you have exhausted our internal appeal process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested, and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For a standard external review, you will be considered to have exhausted the internal appeal process if you have:

- Completed our appeal process and received a written determination on the appeal from us; or
- Filed a non-certification appeal and, except to the extent that you have requested or agreed to a delay, have not received our written decision on appeal within 30 calendar days of the of the date you can demonstrate that a grievance was filed with us, or
- Received notification that we have agreed to waive the requirement to exhaust the internal appeal process.

If your request for a standard external review is related to a retrospective non-certification (a non-certification which happens after you have received the services in question), you will not be eligible to request a standard review until you have completed our internal review process and received a written final determination from us.

If you wish to request a standard external review, you (or your authorized representative) must make this request to the *NCDOI* within 120 calendar days of receiving our written notice of final determination that the services in question are not approved. When processing your request for external review, the *NCDOI* will require you to provide the *NCDOI* with written, signed authorization for the release of any of your medical records that may need to be reviewed for the purposes of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the *NCDOI* will notify you, your authorized representative and your provider of whether your request is complete and whether it is accepted. If the *NCDOI* notifies you that your request is incomplete, you must provide all requested additional information to the *NCDOI* within 150 calendar days of the date of our written notification of final determination. If the *NCDOI* accepts your request, the acceptance will include:

- The name and contact information for the independent review organization (IRO) assigned to your case.
- A copy of the information about your case that we have provided to the *NCDOI*.
- Notice that we will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO).
- Notification that you or your authorized representative may submit additional written information and supporting documentation relevant to the initial non-certification to the assigned IRO within 7 calendar days of the date of the acceptance notice.

If you or your authorized representative choose to provide any additional information to the IRO, you must also provide the same information to us at the same time using the same means of communication (e.g. you must fax the

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information to us if you faxed it to the IRO). When faxing information to us, send it to 888-404-0949. If you choose to mail your information, send it to the address above.

Please note that you may also provide this additional information to the *NCDOI* within the 7-calendar day deadline rather than sending it directly to the IRO and us. The *NCDOI* will forward this information to the IRO and to us within two business days of receiving your additional information.

The IRO will send you or your authorized representative written notice of its determination within 45 calendar days of the date the *NCDOI* received your standard external review request. If the IRO's decision is to reverse the non-certification, we will reverse the non-certification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the non-certification decision. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the non-certification, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

Expedited External Review

An expedited external review of a non-certification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or a standard external review would reasonably be expected by a prudent layperson or a physician with knowledge of the insured's medical condition to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or is causing severe pain that cannot be managed without the requested treatment. If you meet this requirement, you may make a written request to the *NCDOI* for an expedited review after you:

- Receive a non-certification decision from us AND file a request with us for an expedited appeal; or
- Receive an appeal decision upholding a non-certification decision.

You may also make a request for an expedited external review if you receive an adverse first level appeal decision concerning a non-certification of an admission, availability of care, continued stay or Emergency care, but have not been discharged from the inpatient facility.

Within 2 calendar days after receiving a request for an expedited external review, *NCDOI* will notify us that your request has been received and will provide a copy of the request. In consultation with a medical professional, the *NCDOI* will review your request and determine whether it qualifies for expedited review.

NCDOI will notify us with you, your authorized representative and your provider within 2 calendar days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the *NCDOI* may:

- Accept the care for standard external review if our internal appeal process was already completed; or
- Require the completion of our internal appeal process before you may make another request for an external review with the *NCDOI.*

An expedited external review is not available for retrospective non-certification.

The IRO will communicate its decision to you not more than 3 calendar days of the date the *NCDOI* received your request for an expedited external review. If the IRO's decision is to reverse the non-certification, we will, within 1 calendar day of receiving notice of the IRO's decision, reverse the non-certification decision for the requested services or supply that is the subject of the non-certification decision. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the non-certification, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

The IRO's external review decision is binding on us and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same non-certification decision for which you have already received an external review decision.

- By mail: *North Carolina Department of Insurance, Health Insurance Smart NC*, 1201 Mail Center, Raleigh, NC 27699-1201, Toll Free Telephone: (855) 408-1212, (Fax) (919) 807-6865.
- In Person: For the physical address for *Health Insurance Smart NC*, please visit the web-page: https://www.ncdoi.gov/contactscomplaints/contact-ncdoi
- Toll Free Telephone: (855) 408-1212
- Online: https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review for External Review and Request Form.

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Grievance Review Process

This process is separate and distinct from the utilization review/non-certification appeals and grievance procedures outlined above. UnitedHealthcare will address your dissatisfaction concerning non-clinical matters such as availability, delivery, claim handling, contractual issues or quality of health care services.

First-Level Appeal Review

You, or your authorized representative, may voluntarily request a review of any decision, policy, or our actions that affects you. You have 180 calendar days from the date of receipt of any adverse benefit determination to request a review of this determination. You may submit written material for consideration. Within 3 business days after receiving your request, you will be provided the name, address, and telephone number of one of our authorized representatives, with instructions on how to submit additional written material. A written decision, in clear terms, will be issued to you and, if applicable, to your provider within 30 calendar days after receiving your request.

Second-Level Grievance Review

If you are dissatisfied with the first-level grievance review decision, you may make a request for second-level grievance review within 60 calendar days from the date of receipt of your first level grievance review appeal decision. You should make the request to the address above

Upon receiving a request for a second-level grievance review, you will be informed of the following within 10 business days:

- The name, address, and telephone number of the person designated to coordinate the second-level grievance review; and
- A statement of your rights including the right to:
  - Request and receive from us all information relevant to the case.
  - Attend the second-level grievance review.
  - Present your case to the review panel.
  - Submit supporting materials before and at the review meeting.
  - Ask questions to any member of the review panel.
  - Be assisted or represented by a person of your choice who can be, but is not limited to a provider, a family member, employer representative or an attorney.
  - Seek assistance from *Health Insurance Smart NC*.

Upon receiving your request for second-level grievance review, a review panel will be convened. The panel will be comprised of people who were not previously involved in any matter giving rise to the second-level grievance review, and who do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions.

Second-Level Grievance Review Procedures

A review meeting will be scheduled and we will give you notice of the review meeting date and time at least 15 calendar days before the review meeting. The review meeting will be held by teleconference. You have the right to a full review of your grievance even if you do not take part in the review meeting. A decision will be issued within 30 calendar days after we receive a second level grievance review request.

Your right to a full review shall not be conditioned on your appearance at the review meeting.

We will issue a written decision within 7 business days of the review meeting, in clear terms, to you and, if applicable, to your authorized representative. Independent external review through the *NCDOI* is not available for grievance reviews.

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Section 7: General Legal Provisions

Coverage Determination

If we provide you with prior written notice that a service is a Covered Health Care Service, we will not later retract such determination after the services are furnished unless the determination was based upon material misrepresentation by you or your Physician.

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.

Certification of Coverage Form

Please note that as required by the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce a certificate of creditable coverage form for Covered Persons who lose coverage under this *Policy* on or after the effective date of this *Policy*. A certification of prior creditable coverage is a written certification of your period of creditable coverage, and any waiting period and affiliation period, if applicable to you, before coverage begins under the plan.

We will provide a certification of prior creditable coverage when your coverage ends for any of the following reasons:

- At the time you cease to be covered under this *Policy*.
- Upon request on your behalf when the request is made not later than 24 months after the date coverage ends.

"Creditable coverage" means coverage under any of the following: a group health plan; health insurance coverage in the group market or individual market; Part A or part B of *Title XVIII* of the *Social Security Act*; *Title XIX* of the *Social Security Act* (other than coverage consisting solely of benefits under section 1928; Chapter 55 of *Title 10* of the *United States Code*; a medical care program of the *Indian Health Service* or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of *Title 5* of the *United States Code*; a public health plan (as defined in federal regulations); a health benefit plan under *section 5(e) of the Peace Corps Act*; *Title XXI* of the *Social Security Act (State Children's Health Insurance Program)*; short-term limited duration health insurance coverage. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

What Is Our Relationship with Providers?

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

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

What Is Your Relationship with Providers?

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

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You are responsible for all of the following:

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

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we urge 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 urge you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. We will notify you of the opportunity to participate in available programs and of any criteria for eligibility. Contact us at www.myuhc.com/exchange or the telephone number on your ID card if you have any questions.

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

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

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Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

- Interpret Benefits under this *Policy*, including by comparing the cost effectiveness of alternate services or supplies when determining which of the services or supplies will be covered.
- Interpret the other terms, conditions, limitations and exclusions set out in this *Policy*, including the *Schedule of Benefits* and any *Amendments*.
- Make factual determinations related to this *Policy* and its Benefits.

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

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

Who Provides Administrative Services?

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

Amendments to this Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. We have the right to request this information at any reasonable time. This

SAMPLE

applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

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

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

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

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

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

In some cases, as permitted by law, we will choose 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.

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 prior to the expiration of 60 days after written proof of loss has been furnished. No such action shall be brought following the expiration of three years after the time written proof of loss is required to be furnished. In the interest of expediting the resolution of any complaints you might have we urge you to follow the grievance process outlined in *Section 6: Grievance and Appeal Procedure* before you bring any legal proceeding or action against us.

SAMPLE

What Is the Entire Policy?

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

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Section 8: Defined Terms

Air Ambulance - medical transport by helicopter or airplane.

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

SAMPLE

Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.

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. Cosmetic procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child.

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

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

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

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

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

Definitive Drug Test - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

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

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A foster child.
- A child placed for foster care.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The following conditions apply:

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

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

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Please note: a Dependent child enrolled in a postsecondary educational institution will continue to be eligible for coverage during a Medically Necessary leave of absence from the postsecondary educational institution in accordance with all applicable requirements of *Public Law 110-381*, known as *Michelle's Law*.

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

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your Service Area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

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

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

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

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

Emergency Medical Condition or Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity, (including, but not limited to severe pain so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Health Care Services - Health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including pre-Hospital care and ancillary services routinely available to the emergency department. Emergency Health Care Services include:

- 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;

SAMPLE

- 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 18679(e)(3) of the *Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Care Services include items and services otherwise covered under the *Policy* when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using non-medical 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.

  Please note: Prior authorization is not required for Emergency Health Care Services.

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

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:

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- You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- 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.

Facility Based Physician - any Physician that provides services in a facility.

Foster Child - a minor:

- Whose guardian is the Subscriber or Subscriber's spouse, as appointed by the Clerk of Superior Court of any county in North Carolina; or
- Whose primary or sole custody has been assigned to the Subscriber or Subscriber's spouse by court order.

Placement in a foster home means physically residing with a person appointed as a guardian or custodian of a foster child, as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child, with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

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

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

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

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

SAMPLE

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

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

Grievance - means a written complaint submitted by a Covered Person about any of the following:

- Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a Covered Person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the *Policy*.
- Claims payment or handling; or reimbursement for services.
- The contractual relationship between a Covered Person and us.

The outcome of an appeal of a noncertification under this section.

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

Habilitative services are limited to:

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

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S. Food and Drug Administration (FDA)* as Hearing Aids. Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of this *Policy*, they are Hearing Aids).

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

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

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

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

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

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Hospital also includes a North Carolina State tax supported institution, whether or not the institution has an operating room and related equipment for surgery.

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

Infertility - The inability after 12 consecutive months of unsuccessful attempts to conceive a child.

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

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

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

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

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

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

Intensive Outpatient Program - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

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

Medically Necessary – health care services or supplies that are all of the following as determined by *us* or our designees:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, Injury, or disease; and, except as allowed under GS 58-3-255, not for Experimental, Investigational, or for cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, Injury, disease, or its symptoms.

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- Within generally accepted standards of medical care in the community.
- Not solely for your convenience or that of your doctor or other health care provider.

Medically Necessary and Utilization of Generally Accepted Standards of Medical Practice – In addition to generally accepted standards of medical care in the community, we or our designees may utilize Generally Accepted Standards of Medical Practice.

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

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

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

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

Morbid Obesity Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity. (from National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity.)

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

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

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

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

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

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

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

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

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

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

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Act), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Sexual Dysfunction - Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

Short-Term Acute Care Facility - means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.

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

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

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

Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. This does not include a facility primarily for rest, the aged, treatment of substance-related and addictive disorders services, or for care of behavioral health disorders.

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

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

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

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

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

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

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

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

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

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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, regardless of *U.S. Food and Drug Administration (FDA)* approval, 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. These include:

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

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

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Section 9: Outpatient Prescription Drugs

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

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

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

Introduction

Coverage Policies and Guidelines

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

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

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

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

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

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

Submit your claim to:

OptumRx Claims Department,
PO Box 650540,

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Dallas, TX 75265-0540

Designated Pharmacies

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

When Do We Limit Selection of Pharmacies?

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

Coupons, Incentives and Other Communications

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

Special Programs

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

Are Discounts and Incentives Available to You?

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

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

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

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Benefits for Prescription Drug Products

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

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

Prescription Drug Products from a Mail Order Network Pharmacy

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

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

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

PPACA and Preventive Care Medications

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

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

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

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

List of Zero Cost Share Medications

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

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

Outpatient Prescription Drug Exclusions

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

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

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational Services and medications; medications used for experimental or investigational treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational. This exclusion does not apply to any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration (FDA). The drug, however, must be approved by the FDA and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
   - The *National Comprehensive Cancer Network Drugs & Biologics Compendium*;
   - The *ThomsonMicromedex DrugDex*;
   - The *Elsevier Gold Standard's Clinical Pharmacology*; or
   - Any other authoritative compendia as recognized periodically by the *United States Secretary of Health and Human Services.*
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 Prescription Drug 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 certain injectable drugs used for contraception.
12. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
13. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride to prevent dental cavities in children.
14. Certain Prescription Drug Products that are repackaged, relabeled or packaged as a unit dose(s).
15. Prescription Drug Products used for cosmetic purposes.

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16. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Care Service.

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

18. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed for Medically Necessary treatment of any underlying cause of infertility. Certain covered Prescription Drug Products related to treatment of infertility are limited to 3 medical ovulation induction cycles per lifetime per covered person.

19. Prescription Drug Products when prescribed to treat sexual dysfunction and/or impotency.

20. Prescription Drug Products not placed on a tier of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.

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

22. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation

23. Certain New Prescription Drug Products until the date they are reviewed and placed on a tier by our PDL MC and applicable clinical criteria are approved.

24. 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)

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

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

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

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

29. Dental products, including but not limited to prescription fluoride topicals. For further detail, please see *Preventive Services* in *Pediatric Dental Care Services*.

30. A Prescription Drug Product with either:

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

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

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

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

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Defined Terms for Outpatient Prescription Drugs

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

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

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

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

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

List of Zero Cost Share Medications – a list that identifies certain Prescription Drug Products on the Prescription Drug (PDL) that are available at a zero cost share (no cost to you). 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.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy may be a:

- Specialty Network Pharmacy.
- Mail Order Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product, new dosage form, or new indication of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product, new dosage form, or new indication is commercially available following approval by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL MC.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

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

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

Prescription Drug List (PDL) - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may

SAMPLE

find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

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

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles.
  - blood-testing strips – glucose.
  - urine-testing strips – glucose.
  - ketone-testing strips.
  - certain insulin pumps.
  - certain continuous glucose monitors.
  - lancets and lancet devices.
  - glucose meters.
- Medically Necessary drugs for treatment of any underlying cause of infertility, limited to 3 medical ovulation induction cycles per lifetime per Covered Person.

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

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

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

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

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Section 10: Pediatric Dental Care Services

How Do You Use This Document?

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

What Are Defined Terms?

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

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

What Are Covered Dental Care Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

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

Benefits for Pediatric Dental Care Services

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

A. Necessary.

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

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

D. Not excluded as described under Pediatric Dental Exclusions of this section.

Benefits

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

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Pediatric Dental Exclusions

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

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section under *Benefits for Pediatric Dental Care Services.*
3. Dental Care Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
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.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours' notice, telephone consultations and sales tax.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section of the Policy.
17. Dental Care Services otherwise covered under the Policy, but provided after the date individual coverage under the *Policy* ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the *Policy* ends.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered outside of the United States.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

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24. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

25. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

26. Services that exceed the frequency limitations as identified in this section.

Defined Terms for Pediatric Dental Care Services

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

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

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

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

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

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

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:

Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or

Safe with promising efficacy

- For treating a life-threatening dental disease or condition.
- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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Section 11: Pediatric Vision Care Services

How Do You Use This Document?

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

What Are Defined Terms?

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

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

Benefits for Pediatric Vision Care Services

What Are the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Co-payments 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.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

SAMPLE

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.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Fra*mes together.

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.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

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

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

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

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

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

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

Low Vision

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

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:

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- A comprehensive exam of visual functions.
- The prescription of corrective eyewear or vision aids where indicated.
- Any related follow-up care.

- Low vision therapy: Subsequent low vision therapy, if prescribed.

Pediatric Vision Exclusions

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

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

Claims for Low Vision Care Services

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

Reimbursement for Low Vision Care Services

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

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Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

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Section 12: Consolidated Appropriations Act Summary

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

No Surprises Act

Balance Billing

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

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

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

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

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

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

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

Continuity of Care

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

Provider Directories

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

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Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

UnitedHealthcare complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: **UHC_Civil_Rights@uhc.com**

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at: **https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

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Language Assistance Services 1-877-265-9199, TTY 711

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ ኣትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታውቂያ ቁጥርዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا كنت تتحدث اللغة **العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة .اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ।

আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

ATENSION: Yanggen fifino' hao **Chamoru (Chamorro)** guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang i dibåtdi na numiru gi kattå-mu aidentifikasion membro.

請注意：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

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.

SAMPLE

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FA‘AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan),** o lo‘o avanoa mo oe ‘au‘aunaga fesoasoani tau gagana e leai se totogi ma feso‘ota‘iga e leai se totogi i isi faiga, e pei o lomiga e lapopo‘a mata‘itusi. Valaau i le numera e leai se totogi i lau kata faailo o le sui auai (ID).

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

PAUNAWA: Kung nagsasalita ka **ng Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

శ్రద్ధ: మీరు **తెలుగు (Telugu)** మాట్లాడేవారైతే, మీకు ఉచిత భాషా సహాయ సేవలు మరియు పెద్ద ముద్రణ వంటి ఇతర ఫార్మాట్‌లలో కమ్యూనికేషన్‌లు ఉచితంగా లభిస్తాయి. మీ మెంబరు ఐడింటిఫికేషన్ కార్డులోని టోల్-ఫ్రీ నెంబరుకి కాల్ చేయండి.

โปรดทราบ หากคุณพูดไทย **(Thai)** ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

УВАГА: Якщо ви розмовляєте **українською (Ukrainian)**, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом. Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.

توجہ دیں: (Urdu) اگر آپ **اردو** زبان بولتے ہیں تو آپ کے لیے زبان کی معاون خدمات اور دیگر فارمیٹ میں مفت مواصلات، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

LƯU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.

SAMPLE

Notice Concerning Coverage Limitations and Exclusions under the North Carolina Life and Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the Guaranty Association in selecting an insurance company or in selecting an insurance policy.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
RALEIGH NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Coverage

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

SAMPLE

Exclusions from Coverage

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange; or
- they acquired rights to receive payments through a structured settlement factoring transaction.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- a policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

Limits on Amount of Coverage

The act also limits the amount the association is obligated to pay out as follows:

- the guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- the guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
- the guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
- the guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

SAMPLE