OPTIMUM CHOICE, INC.

Individual Exchange Medical Policy

10175 Little Patuxent Parkway, 6th Floor

Columbia, MD 21044

(877) 445-4263

Virginia

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Agreement and Consideration

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

Guaranteed Renewable Subject to Listed Conditions

This Policy shall renew at the option of the individual, subject to the conditions listed in this provision. We may refuse to renew this Policy:

- When you fail to pay the required Premiums in accordance with the terms of this Policy.
- If there is fraud or intentional misrepresentation made by you or with your knowledge in filing a claim for Benefits.
- If all policies issued on this form, with the same type and level of Benefits, are no longer available to residents of the state where you live.
- If you no longer reside, live, or work within the Service Area.

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

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, 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 75 days' notice of any plan to take an action or make a change permitted by this paragraph 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.

Please see *Section 4: When Coverage Ends* for more information about when coverage may end.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this Policy, please contact us at the address or telephone number stated above. If you have been unable to contact or obtain satisfaction from us, you may contact the Virginia Bureau of Insurance at:

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State Corporation Commission

Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

(804) 371-9741 (local or out-of-state calls)

(804) 371-9944 (fax number)

(800) 552-7945 (in-state toll free number)

(877) 310-6560 (national toll-free number)

E-mail: bureauofinsurance@scc.virginia.gov

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us or the Virginia Bureau of Insurance, have your Policy number available.

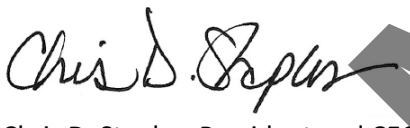
We recommend that you familiarize yourself with our complaint/appeal procedure and make use of it before taking any other action.

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 receive 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.

Optimum Choice, Inc.



Chris D. Staples, President and CEO

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What Is the Policy?

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

This Policy includes:

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

Can This Policy Change?

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

Other Information You Should Have

We have the right to change, 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 The Commonwealth of Virginia. This Policy is governed by The Commonwealth of Virginia law.

We are subject to regulation in this Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance (pursuant to Title 38.2) and the Virginia Department of Health (pursuant to Title 32.1).

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

If you have any questions regarding an appeal or grievance concerning the healthcare services that you have been provided which in your opinion we have not satisfactorily addressed, you may contact the Office of the Managed Care Ombudsman for assistance as indicated below:

Office of the Managed Care Ombudsman

Bureau of Insurance

[P.O. Box 1157]

[Richmond, VA 23218]

Phone number: [(877) 310-6560]

Fax number: [(804) 371-9944

[Ombudsman@scc.virginia.gov]

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Your Responsibilities

Enrollment and Required Premiums

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

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. When prior authorization is the responsibility of an in-Network provider, any reduction or denial of Benefits will not affect you. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment or Co-insurance 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*. Amounts which you are required to pay, as shown in the Schedule of Benefits, are based on Allowed Amounts. The Allowed Amounts provision near the end of the Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

We will keep Out-of-Pocket Limit records and will notify you no later than 30 days after such limit is reached. We will not charge any further Annual Deductible, Co-payments or Co-insurance for the applicable benefit period when Out-of-Pocket Limit are reached and will promptly refund any excess Annual Deductible, Co-payments or Co-insurance paid.

Pay the Cost of Excluded Services

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

Show Your ID Card

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

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File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, as a result of an Emergency or we refer you to an out-of-Network provider, we pay out-of-Network providers directly. However, if you have already paid the out-of-Network provider, we will accept a request for payment submitted by you. If you submit a request for payment, 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 and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Amendments.

Make factual determinations relating to Benefits.

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines 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.

Any exercise of such discretion is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

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, except for Emergency Services and Emergency air ambulance services provided to a Covered Person or non-Emergency Services provide to a Covered Person at a Network Facility by an out-of-Network provider, 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. Out-of-Network providers may not bill you for (i) Emergency services provided to an enrollee or (ii) non-emergency services provided to an enrollee at a Network Facility if the non-emergency services involve Surgical or Ancillary Services provided by an out-of-

SAMPLE

Network provider. 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. Reimbursement levels for Emergency Health Care Services and non-emergency services provided at a Network Facility by an out-of-Network provider will be based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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

UnitedHealthcare Individual Exchange Policy

Optimum Choice, Inc.

Schedule of Benefits

Covered Health Care Services Schedule of Benefits

UHC Silver Value

VA0049, $5,000

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. Referrals are not required to access Covered Health Care Services, as this plan does not require Primary Care Physician gating.

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 an Optimum Choice, Inc. Individual Exchange Network provider. You can confirm that your provider is an Optimum Choice, Inc. Individual Exchange Network provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com/exchange. You should confirm that your provider is an Optimum Choice, Inc. Individual Exchange Network provider.

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

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

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

Covered Health Care Services for Surgical and Ancillary Services provided at 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*.

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

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

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

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

Care Management

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

Does Prior Authorization Apply

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

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

What Will You Pay for Covered Health Care Services?

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

Payment Information

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drugs* section. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Pediatric Dental Care Services* section and the *Pediatric Vision Care Services* section. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a 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	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.

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Payment Term And Description	Amounts
Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. No individual Covered Person on a family plan will have to pay an Annual Deductible higher than the per Covered Person Annual Deductible for Covered Health Care Services. Charges for Covered Health Care Services incurred by remaining Covered Persons on the family plan who have not met their per Covered Person Annual Deductible will continue to accrue towards both their per Covered Person Annual Deductible and the family Annual Deductible. When the total amount of expenses for Covered Health Care Services accruing towards the family Annual Deductible meets the family Annual Deductible, all Covered Persons on the family plan will have satisfied Annual Deductible obligations under this Policy, regardless of whether an individual Covered Person has met his or her per Covered Person Annual Deductible.	
Out-of-Pocket Limit	
The maximum you or someone on your behalf pays per year, to the extent allowed by law, for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drugs* section. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this Schedule of Benefits including the *Pediatric Dental Care Services* section and the *Pediatric Vision Care Services* section. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. No individual Covered Person on a family plan will have to pay an Out-of-Pocket Limit higher than the per Covered Person Out-of-Pocket Limit. Total combined out-of-pocket expenses for all Covered Persons on a family plan shall not exceed the family Out-of-Pocket Limit, regardless of the number of family members who contribute to those out-of-pocket expenses. 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.	$11,000 per Covered Person, not to exceed $22,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment.	

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Payment Term And Description	Amounts
• The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

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?**	**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:* 50%	Yes	Yes
	Air Ambulance: 50%	Yes	Yes
	Water Ambulance: 50%	Yes	Yes
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under Allowed Amounts in this *Schedule of Benefits.*	*Ground Ambulance:* 50%	Yes	Yes
	Air Ambulance: 50%	Yes	Yes
	Water Ambulance: 50%	Yes	Yes
Autism Spectrum Disorder			
	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.		
Clinical Trials			

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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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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 and Services for Medical Treatments			
	50%	Yes	Yes
Dental Services - Accident Only			
	50%	Yes	Yes
Diabetes Services			
Diabetes Self-Management and Educational Services For Covered Persons with Type 1 or Type 2 diabetes, the following services are offered at $0 cost share: • Retinal eye exams, limited to 1 exam per plan year. • Preventive foot care. • Nutritional counseling. • Certain lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HbA1c) in diabetics. This does not apply to Covered Persons with pre-diabetes or gestational diabetes diagnoses.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		

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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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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 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.	50%	Yes	Yes
Emergency Health Care Services - Outpatient			
Includes Mobile Crisis Response Services and support and stabilization services provided in a Residential Crisis Stabilization Unit or Crisis Receiving Center. **Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER Services, the Benefits provided as described under *Hospital - Inpatient Stay* will	*Facility Services* 50%	Yes	Yes
	Physician Services 50%	Yes	Yes

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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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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			
	50%	Yes	Yes
Eyeglasses for Disease or Injury			
	50%	Yes	Yes
Gender Dysphoria			
It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drugs* section.		
Habilitative Services			
	Inpatient Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies are limited per year as follows: • 30 visits for any combination of physical therapy or occupational therapy. • 30 visits for speech therapy.	*Outpatient* 50%	Yes	Yes

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
The limits for physical, occupational, and speech therapy will not apply if care is received as part of the following Benefits: • Hospice Care • Early Intervention Services • Autism Spectrum Disorder • Mental Health Care and Substance-Related and Addictive Disorders Services When you receive physical, occupational or speech therapy in the home, the home health care visit limit will apply instead of the therapy services limits listed above.			
Hearing Aids			
Benefits are only available for Hearing Aids and related services for children 18 years of age or younger. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist. Coverage includes one Hearing Aid per hearing-impaired ear, up to a cost of $1500, every 24 months.	None	Yes	No
Home Health Care			
Limited to 100 visits per year. This visit limit does not include any service which is billed only for the	50%	Yes	Yes
	Private Duty Nursing 50%	Yes	Yes

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a Network provider we identify. This limit does not apply to home infusion therapy, home dialysis, or Mental Health Care and Substance Related and Addictive Disorders Services. This home health care visit limit applies to any combination of physical, occupational, speech, or cardiac rehabilitation therapy received in the home instead of any individual therapy limits. Private-duty nursing services are limited to 16 hours per year. Private-duty nursing services are not subject to the 100 visits per year limit for home health care.			
Hospice Care			
The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care Benefit.	50%	Yes	Yes
Hospital - Inpatient Stay			
	50%	Yes	Yes
Lab, X-Ray and Diagnostics – Outpatient			
Lab Testing – Outpatient	$20 per service at a freestanding lab or in a Physician's office	Yes	No

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**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	50% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
Medically Necessary diagnostic breast examinations and Prostate Specific Antigen (PSA) testing is provided without cost-share.	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			
	50% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes
Manipulative Treatment			
Limited to 30 visits per year. The limit applies separately for rehabilitative and habilitative services.	50%	Yes	Yes
Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient (includes Residential Treatment)		
	50%	Yes	Yes
	Outpatient		
Telehealth services are available.	50% for Intensive Outpatient Program	Yes	Yes

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
The visit limits for *Habilitative Services, Rehabilitation Services - Outpatient Therapy,* and *Home Health Care* do not apply to Mental Health Care and Substance-Related and Addictive Disorders Services.	50% for Partial Hospitalization	Yes	Yes
	50% for all other outpatient services including Intensive Behavioral Therapy, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, and Psychological Testing	Yes	Yes
	Office Visit		
	$35 per visit	Yes	No
Necessary Medical Supplies			
	50%	Yes	Yes
Orthotics			
	50%	Yes	Yes
Pharmaceutical Products - Outpatient			
Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. **Note**: Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drugs* section.	50%	Yes	Yes
Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-	*Inpatient*		
	50%	Yes	Yes

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Outpatient*		
	50% at a freestanding center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based center	Yes	Yes
Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostic - Outpatient. • Major diagnostic and nuclear medicine described under Major Diagnostic and Imaging - Outpatient. • Outpatient Pharmaceutical Products described under Pharmaceutical Products - Outpatient. • Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic. • Outpatient surgery procedures described under Surgery - Outpatient.	$35 per visit for services provided by your Primary Care Physician	Yes	No
	$75 per visit for services provided by a Network Specialist	Yes	No
	50% for services provided by any other Network Physician	Yes	Yes

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.			
Pregnancy - Maternity Services			
In accordance with Virginia law and as described in the Policy, Benefits are provided for a home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
Breast pumps	None	Yes	No
Prosthetic Devices			
Benefits are limited to one wig per year as needed following cancer treatment.	30%	Yes	Yes
Reconstructive Procedures			
Including Cleft Lip and Cleft Palate Treatment	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 30 visits for any combination of physical therapy and occupational therapy. • 30 visits for speech therapy.	50%	Yes	Yes

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Unlimited visits for pulmonary and cardiac rehabilitation therapy. The limits for physical, occupational, and speech therapy will not apply if care is received as part of the following Benefits: • Hospice Care • Early Intervention Services • Autism Spectrum Disorder • Mental Health Care and Substance-Related and Addictive Disorders Services When you receive physical, occupational or speech therapy in the home, the home health care visit limit will apply instead of the therapy services limits listed above.			
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	50%	Yes	Yes
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limit will be any combination of Skilled Nursing Facility or Inpatient Rehabilitation Facility Services limited to 100 days per Inpatient Stay.	*Skilled Nursing Facility*		
	50%	Yes	Yes
	Inpatient Rehabilitation Facility		
	50%	Yes	Yes
Surgery - Outpatient			

SAMPLE

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50% at a freestanding surgical center	Yes	Yes
	50% 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)			
	50%	Yes	Yes
Therapeutic Treatments - Outpatient			
Including dialysis, chemotherapy, and infusion services, and home treatment of hemophilia and congenital bleeding disorders. Visit limits do not apply for chemotherapy and radiation therapy given as palliative care. Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment (DME).*	*Chemotherapy* 50%	Yes	Yes
	Dialysis 50%	Yes	Yes
	Infusion Therapy 50%	Yes	Yes
	Radiation 50%	Yes	Yes
	All Other Treatments 50%	Yes	Yes
Transplantation Services			
Transplantation services must be received from a Designated Provider. Covered expenses for lodging and ground transportation will be limited to the current limits set forth in the *Internal Revenue Code*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

SAMPLE

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?**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
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* $55 per visit	Yes	No
	Out-of-Network $55 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

Continuity of Care

If you have an existing provider-patient relationship with a Network Provider who is terminated from the Network for reasons other than cause, we can arrange for continuation of Covered Health Care Services rendered by the terminated Provider for the time periods shown below. Co-payments, Co-insurance, deductibles, or other cost sharing components will be the same as you would have paid for a provider currently contracting with us. The terminated Provider will be reimbursed in accordance with our agreement with the Provider existing immediately before the Provider's termination of participation.

Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Policy are:

- If a Covered Person has been medically confirmed to be pregnant at the time the Network Provider is terminated, coverage for treatment by the terminated Provider will continue until the postpartum services related to the delivery are completed.
- If a Covered Person is undergoing a specified course of treatment for a terminal illness or a related condition at the time the Network Provider is terminated, coverage for care directly related to treatment of the terminal illness will continue for the remainder of the Covered Person's life or until coverage under the Policy terminates.
- If a Covered Person has been determined by a medical professional to have a life-threatening condition at the time the Network Provider is terminated, coverage for treatment will continue for up to 180 days for care directly related to the life-threatening condition.
- If a Covered Person is admitted to and receiving treatment in an inpatient facility at the time the Network Provider is terminated, coverage treatment will continue until the Covered Person is discharged from the facility.

SAMPLE

- For any other Covered Health Care Services, coverage will continue for 90 days after the date the Provider has been terminated from the Network.

An existing provider-patient relationship means the Network Provider has rendered health care services to the Covered Person or admitted or discharged the Covered Person within the 12 months prior to the provider's termination from the Network.

As used in this provision, the term "provider" includes a provider group.

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 ***Surgical or Ancillary Services received at 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 Network 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 Network 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 Network 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 Network 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 Network Facilities from out-of-Network Physicians when such services are either Surgical or Ancillary Services, the Allowed Amount is based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

IMPORTANT NOTICE: Out-of-Network Facility-based Physicians may not bill you for any difference between the Physician's billed charges and the Allowed Amount described here. For Surgical or Ancillary Services, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Network 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 a rate agreed upon by the out-of-Network provider or a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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

SAMPLE

bill you, for amounts in excess of your applicable Network 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 Network Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Policy*.

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

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

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

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

- For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable gap fill relative value scale information.
- For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider’s billed charge.

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

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

Provider Network

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

SAMPLE

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.

Designated Providers

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

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

You or your Network Physician must notify us of special service needs (such as transplants) 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.

SAMPLE

Outpatient Prescription Drugs Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments or 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 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 or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

Do Prior Authorization Requirements Apply?

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

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

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

If a prior authorization is not obtained 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 a prior authorization is not obtained 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, the amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment 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 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.

SAMPLE

Does Step Therapy Apply?

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

However, you or your prescriber may request an override exception and we will provide determination no later than 72 hours after receipt of the request for the step therapy override exception. An expedited exception request will be reviewed with a determination provided no later than 24 hours following the request.

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 act on such requests within one (1) business day of receipt of the request, and 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 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.

You may obtain coverage without additional cost sharing beyond that which is required of formulary Prescription Drug Products for a non-formulary drug if we determine, after consultation with the prescribing Physician, that the formulary Prescription Drug Product is inappropriate for your condition. You may obtain coverage without additional cost sharing beyond that which is required of formulary Prescription Drug Products if:

- You have been taking or using the non-formulary Prescription Drug Product for at least six months prior to its exclusion from the formulary; and
- The prescribing Physician determines that either the formulary Prescription Drug Product is inappropriate therapy for your condition or that changing drug therapy presents a significant health risk.

Urgent Requests

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

External Review

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

Expedited External Review

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

Your Right to Request a Step Therapy Exception

We understand that situations may arise in which it may be Medically Necessary to take a medication for a particular medical condition or at a dose exceeding the quantity limit. In these instances, your prescribing Physician can request a prior authorization. Your prescribing Physician may need to provide information on diagnosis and medication history

SAMPLE

and/or evidence in the form of documents, records, or lab tests that establishes the use of the requested Prescription Drug Product. If prior authorization is not obtained before the Prescription Drug Product is dispensed, you will be responsible for paying all charges and no Benefits will be paid. You have the right to appeal any denial.

A prior authorization for a step therapy exception request will be approved if the prescribing provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing provider's statement that:

1. The required Prescription Drug Product is contraindicated.
2. The required Prescription Drug Product would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
3. The Covered Person has tried the step therapy-required Prescription Drug Product while under his or her current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
4. The Covered Person is currently receiving a positive therapeutic outcome on a Prescription Drug Product recommended by his or her provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

We have made the process simple and easy. Your prescribing Physician may electronically, by phone, or by fax send the prior authorization request to OptumRx®, which is Optimum Choice, Inc.'s pharmacy benefit manager.

We or our designee will make a determination on a standard request and notify you or your representative of our determination within 72 hours following the receipt of the request, including hours on weekends. In cases where exigent circumstances exist, we or our designee will provide a written or electronic determination to you or your representative within 24 hours following receipt of the request, including hours on weekends, indicating whether the request is approved, denied, or requires supplementation. You have the right to appeal any denial.

What Do You Pay?

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

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

You are responsible for paying the applicable Co-payment or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment 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 the following under your Policy may not be included in calculating any Out-of-Pocket Limit stated in your Policy:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

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 or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	For Prescription Drug Products at a Retail Network Pharmacy you are responsible for paying the lowest of the following: • The applicable Co-payment 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 or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. You are not responsible for paying a Co-payment 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. The total amount of Co-payment, Co-insurance, or deductible you pay for covered prescription insulin drugs will not exceed $35 per 30-day supply in aggregate, including situations where more than one insulin drug is prescribed. The total amount of Co-payment, Co-insurance, or deductible you pay for covered diabetic equipment and supplies will not exceed $35 per 30-day supply in aggregate, including situations where more than one piece of equipment or type of supply is prescribed.

SAMPLE

Schedule of Benefits Information Table

- Your Co-payment 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 a 30-day supply with three refills.
- You will be charged a Co-payment 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.
- For covered prescription hormonal contraceptives, up to a 12-month supply may be dispensed or furnished at one time.

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	$85 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$212.50 per Prescription Order or Refill. Subject to payment of the Annual Deductible.	$212.50 per Prescription Order or Refill. Subject to payment of the Annual Deductible.
Tier 4	45% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	45% of the Prescription Drug Charge. Subject to payment of the Annual Deductible.	45% 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 Co-insurance for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

Schedule of Benefits Information Table

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the 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 1 time per six-months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.* Periodic oral evaluation, beginning with the eruption of the first tooth. Limited oral evaluation - problem focused. Teledentistry - synchronous - real time encounter.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. Oral evaluations for a patient under three years of age and counseling with primary caregiver. Comprehensive oral evaluation. Comprehensive periodontal evaluation. Detailed and extensive oral evaluation - problem focused.	
Intraoral Radiographs (X-ray) Limited to 1 series of films per 60 months. Intraoral - comprehensive series of radiographic images. Intraoral – comprehensive series of radiographic images – image capture only. Intraoral tomosynthesis – comprehensive series of radiographic images Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only.	None
The following services are limited to 2 per 12 months. Intraoral - periapical first radiographic image. Intraoral - periapical - each additional radiographic image. Extraoral – 2-D projection radiographic image created using a stationary radiation source and detector. Extraoral – each additional radiographic image. Bitewings - single radiographic image Intraoral – bitewing radiographic image – image capture only.	None
Any combination of the following services is limited to 1 series of films per 12 months. Bitewings - two films. Bitewings - three films. Bitewings - four films. Vertical bitewings. Intraoral tomosynthesis – comprehensive series of radiographic images. Intraoral tomosynthesis – bitewing radiographic image – image capture. Intraoral - bitewing radiographic image - image capture only.	None
Limited to 1 time per 60 months. Panoramic radiograph image.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Panoramic radiographic image - image capture only. 2-D Cephalometric radiographic image - image capture only.	
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 intraorally or extra orally. Diagnostic casts. 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) *Limited to one time every six-months.*	None
Fluoride Treatments *Limited to one time every six-months.*	None
Sealants (Protective Coating) *The following services are Limited one per Lifetime per tooth.* Sealant - per tooth - unrestored permanent molar. Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None
Space Maintainers (Spacers) *Limited to one per 2 years per quadrant (unilateral) or arch (bilateral).* 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.	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 Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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.	50%
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. Resin-based composite - two surfaces, anterior. Resin-based composite - three surfaces, anterior. Resin-based composite - four or more surfaces or involving incised angle, anterior. Resin-based composite – one surface, posterior. Resin-based composite – two surfaces, posterior. Resin-based composite – three surfaces, posterior. Resin-based composite – four or more surfaces, posterior.	50%
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)	
The following services are subject to a limit of one per tooth every 60 months. Onlay - metallic - two surfaces. Onlay - metallic - three surfaces. Onlay - metallic - four or more surfaces. Onlay - porcelain/ceramic – two surfaces	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Onlay - porcelain/ceramic – three surfaces Onlay - porcelain/ceramic – 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. 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. Resin-based composite crown, anterior. Re-cement or re-bond inlay. Re-cement or re-bond crown. Re-cement or re-bond indirectly fabricated or prefabricated post and core. Prefabricated porcelain/ceramic crown – primary tooth. Prefabricated resin crown. Prefabricated stainless steel crown with resin window. Prefabricated esthetic coated stainless steel crown – primary tooth.	
The following service is not subject to a frequency limit. Protective restoration.	50%
The following services are not subject to a frequency limit. Core buildup, including any pins. Pin retention - per tooth, in addition to crown.	50%
The following service is not subject to a frequency limit. Prefabricated post and core in addition to crown.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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.	50%
Endodontics - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Pulp cap - direct (excluding final restoration). Pulp cap - indirect (excluding final restoration). Therapeutic pulpotomy (excluding final restoration). Pulpal debridement, primary and permanent teeth. *The following service is not subject to a frequency limit.* Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. *The following services are not subject to a frequency limit.* Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	50%
The following services are limited to one per lifetime per tooth. Endodontic therapy anterior tooth (excluding final restoration). Endodontic therapy, premolar tooth(excluding final restoration). Endodontic therapy molar tooth (excluding final restoration). Retreatment of previous root canal therapy - anterior. Retreatment of previous root canal therapy - bicuspid. Retreatment of previous root canal therapy - molar.	50%
The following services are not subject to a frequency limit. Apexification/recalcification - initial visit. Apexification/recalcification - interim medication replacement. Apexification/recalcification - final visit.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are limited to one per lifetime per tooth. Apicoectomy - anterior. Apicoectomy–premolar (first root). Apicoectomy – molar (first root). Apicoectomy - each additional root. Root amputation - per root. Retrograde filling – 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.	50%
The following services are not subject to a frequency limit. Intraorifice barrier Hemisection (including any root removal), not including root canal therapy.	50%
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 24 months per quadrant. Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.	50%
The following services are limited to one every 36 months. Gingival flap procedure, including root planing - one to three 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.	50%
The following services are limited to one every 60 months.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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 bounded teeth spaces per quadrant. Bone replacement graft - retained natural tooth - first site in quadrant. Removal of non-resorbable barrier	
The following services are not subject to a frequency limit. Pedicle soft tissue graft procedure. 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.	50%
The following services are limited to one time per quadrant every 24 months. Periodontal scaling and root planing - four or more teeth per quadrant. Periodontal scaling and root planing - one to three teeth per quadrant. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	50%
The following service is limited to a frequency of one per 12 months. Full mouth debridement to enable comprehensive evaluation and diagnosis.	50%
The following service is limited to two times every 12 months. Periodontal maintenance.	50%
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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 - flexible base (including any clasps, rests, and teeth) Immediate mandibular partial denture - flexible base (including any clasps, 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). 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.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Adjust partial denture - maxillary. Adjust partial denture - mandibular. Repair broken complete denture base. Repair broken complete denture base - mandibular. Repair broken complete denture base - maxillary. Replace missing or broken teeth - complete denture. Repair resin denture base. Repair resin partial denture base - mandibular. Repair resin partial denture base - maxillary. Repair cast framework. Repair cast partial framework - mandibular. Repair cast partial framework - maxillary. Repair or replace broken retentive/clasping materials - per tooth. Replace broken teeth - per tooth. Add tooth to existing partial denture. Add clasp to existing partial denture.	
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. Rebase complete maxillary denture. Rebase maxillary partial denture. Rebase mandibular partial denture.	50%
The following services are limited to relining performed more than 6 months after the initial insertion with a frequency limitation of one time per 24 months. 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). Reline mandibular partial denture (laboratory). Add metal substructure to acrylic full denture (per arch).	50%
The following services are not subject to a frequency limit. Tissue conditioning (maxillary).	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Tissue conditioning (mandibular). Maxillofacial prosthetics (mandibular/feeding aids). Soft liner for complete or partial removable denture - indirect.	
Bridges (Fixed partial dentures) - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Pontic – indirect resin based composite. 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. Pontic - resin with high noble metal. Pontic - resin with base metal. Pontic - resin with noble metal.	50%
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.	50%
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.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Retainer crown - full cast high noble metal. Retainer crown - full cast predominately base metal. Retainer crown - full cast noble metal.	
The following service is not subject to a frequency limit. Re-cement or re-bond fixed partial denture.	50%
The following service is not subject to a frequency limit. Fixed partial denture repair necessitated by restorative material failure.	50%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. Extraction, erupted tooth or exposed root. Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. Removal of impacted tooth - soft tissue. Removal of impacted tooth - partially bony. Removal of impacted tooth - completely bony. Removal of impacted tooth - completely bony with unusual surgical complications. Surgical removal of residual tooth roots. Coronectomy - intentional partial tooth removal	50%
The following service is not subject to a frequency limit. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	50%
The following services are not subject to a frequency limit. Surgical access of an unerupted tooth. Incisional biopsy of oral tissue – hard (bone, tooth). Incisional biopsy of oral tissue – soft. Brush biopsy – transepithelial sample collection.	50%
The following services are not subject to a frequency limit. Alveoloplasty in conjunction with extractions - per quadrant. Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. Alveoloplasty not in conjunction with extractions - per quadrant.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	
The following services are not subject to a frequency limit. Removal of odontogenic cyst, growth, or tumor lesion diameter up to 1.25 cm. Removal of odontogenic cyst, growth, or tumor lesion greater than 1.25 cm. Removal of lateral exostosis (maxilla or mandible).	50%
The following services are not subject to a frequency limit. Incision and drainage of abscess. Incision and drainage of abscess - intraoral soft tissue – complicated (includes drainage of multiple fascial spaces). Marsupialization of odontogenic cyst. Incision and drainage of abscess, intraoral soft issue. Suture of recent small wounds up to 5 cm. Bone replacement graft for ridge preservation - per site. Buccal/labial frenectomy (frenulectomy/frenuloplasty). Lingual frenectomy (frenulectomy/frenuloplasty). Excision of pericoronal gingiva.	50%
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	50%
Adjunctive Services - (Subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. Palliative (Emergency) treatment of dental pain - minor procedure.	50%
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.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Therapeutic parenteral drug single administration. Local anesthesia not in conjunction with operative or surgical procedures Local anesthesia in conjunction with operative or surgical procedures Evaluation for moderate sedation, deep sedation or general anesthesia.	
Covered only when clinically Necessary. Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	50%
The following are 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. Occlusal orthotic device, by report (covered only for temporomandibular pain, dysfunction, grinding or clenching of teeth, or associated musculature).	50%
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one time every 60 months. Endosteal implant. Surgical placement of interim implant body. Eposteal implant. Transosteal implant, including hardware. Implant supported complete denture. Implant supported partial denture. Connecting bar implant or abutment supported. Prefabricated abutment. Custom abutment. Abutment supported porcelain ceramic crown. Abutment supported porcelain fused to high noble metal. Abutment supported porcelain fused to predominately base metal crown. Abutment supported porcelain fused to noble metal crown. Abutment supported cast high noble metal crown. Abutment supported cast predominately base metal crown.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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. 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.	

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
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. Implant removal. 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. 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.	50%
The following services are limited to one every 36 months.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Guided tissue regeneration – resorbable barrier, per implant. Guided tissue regeneration – non-resorbable barrier, per implant.	
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by us, only for Covered Persons with dysfunctional, handicapping malocclusion. 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. Both removable and fixed appliance therapy for thumb sucking and tongue thrusting are covered. 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, except as noted, as long as benefits have been prior authorized. Limited orthodontic treatment of the primary dentition. Limited orthodontic treatment of the transitional dentition. Limited orthodontic treatment of the adolescent dentition. Comprehensive orthodontic treatment of the transitional dentition. Comprehensive orthodontic treatment of the adolescent dentition. Removable appliance therapy. Fixed appliance therapy. 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.	50%

SAMPLE

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Repair of fixed retainer, includes reattachment - mandibular. Replacement of lost or broken retainer. Unspecified orthodontic procedure, by report.	

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 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

When obtaining these Vision Care Services from a Spectera Eyecare Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

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

Annual Deductible

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

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

Schedule of Benefits Information Table

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

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		50%
• Bifocal		50%
• Trifocal		50%
• Lenticular		50%
Lens Extras	Once every 12 months.	
• Polycarbonate Lenses		None Not subject to payment of the Annual Deductible.
• Standard Scratch-Resistant Coating		None Not subject to payment of the Annual Deductible.
• Tinted Lenses		80% of the billed charge
• Oversized Lenses		80% of the billed charge

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Blended Segment Lenses		80% of the billed charge
• Intermediate Vision Lenses		80% of the billed charge
• Standard Progressives		80% of the billed charge
• Premium Progressives		80% of the billed charge
• Photochromic Glass Lenses		80% of the billed charge
• Plastic Photosensitive Lenses		80% of the billed charge
• Polarized Lenses		80% of the billed charge
• Hi-index Lenses		80% of the billed charge
• Standard Anti-Reflective Coating		80% of the billed charge
• Premium Anti-Reflective Coating		80% of the billed charge
• Ultra Anti-Reflective Coating		80% of the billed charge
• Ultraviolet Protective Coating		80% of the billed charge
Eyeglass Frames	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		50%
• Eyeglass frames with a retail cost of $130 - 160.		50%
• Eyeglass frames with a retail cost of $160 - 200.		50%
• Eyeglass frames with a retail cost of $200 - 250.		50%
• Eyeglass frames with a retail cost greater than $250.		50%
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.	50%
Necessary Contact Lenses	Limited to a 12 month supply.	50%
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us.	Once every 24 months.	

SAMPLE

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Reimbursement will be limited to the amounts stated.		
• Low vision testing		None Not subject to payment of the Annual Deductible.
• Low vision therapy		25% of billed charges. Not subject to payment of the Annual Deductible.

SAMPLE

Table of Contents

Introduction to Your Policy 4
Your Responsibilities 5
Our Responsibilities 7
[Schedule of Benefits] 9
Section 1: Covered Health Care Services 11
Section 2: Exclusions and Limitations 35
Section 3: When Coverage Begins and Premiums 45
Section 4: When Coverage Ends 47
Section 5: How to File a Claim 50
Section 6: Questions, Complaints and Appeals 49
Section 7: General Legal Provisions 59
Section 8: Defined Terms 63
Section 9: Coordination of Benefits 75
Section 10: Outpatient Prescription Drugs 80
Section 11: Pediatric Dental Care Services 88
Section 12: Pediatric Vision Care Services 89
Section 13: Consolidated Appropriations Act Summary 93

SAMPLE

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

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

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, Air, or Water Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed. Air emergency transportation by fixed wing or rotary wing when transportation to an acute care Hospital is Medically Necessary and ground or water transportation is not appropriate.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, water 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.

SAMPLE

Benefits also include Medically Necessary treatment of a Sickness or Injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Prior authorization is not required for ambulance services for Emergency medical conditions.

In accordance with Virginia law, we will provide reimbursement for Benefits under this provision directly to the provider of such services when we have been presented with an assignment of benefits by the provider of the ambulance services.

Providers may not balance bill you for out-of-Network Emergency air ambulance services or non-emergency out-of-network air ambulance services authorized by Us.

Autism Spectrum Disorder

Diagnosis of Autism Spectrum Disorder, including Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

Treatment of Autism Spectrum Disorder, which shall be identified in a treatment plan and includes the following Medically Necessary care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist:

- Behavioral health treatment, which means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. This includes applied behavioral analysis (ABA) services which include the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior' provided by a Board-Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Pharmacy care, which means medications prescribed by a licensed physician and any health-related services Medically Necessary to determine the need or effectiveness of the medications.
- Psychiatric care provided by a licensed psychiatrist.
- Psychological care provided by a licensed psychologist.
- Therapeutic care, which means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers. Therapeutic care provided for the treatment of Autism Spectrum Disorder will not be subject to the visit limitations applicable to physical therapy, occupational therapy, and speech therapy.

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.

SAMPLE

- The clinically appropriate monitoring of the effects of the service or item, or
- The prevention of complications.

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain 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).*
  - An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the *Office of Protection from Research Risks of the NCI*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

SAMPLE

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

Dental Anesthesia and Services for Medical Treatments

General anesthesia and Hospital or Alternate Facility charges when the dentist and the Physician determine that such services are necessary for the safe and effective treatment of a dental condition. Benefits are provided only when a Covered Person meets at least one of the following conditions:

- Is a child under five years of age.
- Is severely disabled.
- Has a medical condition and requires admission to a Hospital or Alternate Facility and general anesthesia for dental treatment.

Covered Health Care Services must be provided under the direction of a Physician or dentist. Benefits are not available for the diagnosis or treatment of dental disease.

Covered Health Care Services include dental services, including x-rays, extractions, and anesthesia, to prepare the mouth for medical treatments such as radiation therapy to treat cancer and prepare for transplants.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.

For Injuries occurring on or after the effective date of coverage, you must seek care within 12 months of the date the Injury was sustained or as soon after that as possible to be a Covered Health Care Service under the Policy or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits include dental appliances needed to treat an accidental injury to the teeth and the repair of existing dental appliances damaged as a result of accidental injury to the jaw, mouth or face as well as dental services. Benefits for treatment of accidental Injury are limited to Medically Necessary treatment.

Please note that injury caused by chewing or biting an object or substance placed in the Covered Person's mouth is not considered an accidental Injury, regardless of whether the Covered Person knew the object or substance was capable of causing such Injury if chewed or bitten. 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 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

Diabetes Services

Diabetes Self-Management and Training and Education Services

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

SAMPLE

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 are described under the *Outpatient Prescription Drugs* section. Diabetes equipment and supplies are not considered to be Durable Medical Equipment.

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

Durable Medical Equipment (DME)

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

DME includes, but isn't limited to:

- Canes.
- External components of, and batteries for, cochlear implants and other implantable hearing devices.
- Commode chairs.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Infusion pumps.
- Nebulizers.
- Negative pressure wound therapy devices (wound vacuums).
- Oxygen equipment, oxygen, and oxygen concentrator.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Medically Necessary Ventilator, or APAP, BPAP, or CPAP, oral devices and/or sleep treatment.
- Walkers.
- Wheelchairs and batteries for powered 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.* Benefits are also available for maintenance and supplies needed for use of the equipment, such as a battery for a powered wheelchair.

SAMPLE

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.

Diabetes equipment and supplies are not considered to be Durable Medical Equipment.

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. Coverage shall be provided without the need for prior authorization and regardless of the final diagnosis rendered to the Covered Person.

Benefits include the Facility charge, supplies and all professional services required to Stabilize your condition and/or begin treatment. Benefits also include diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and stabilize a patient with an Emergency medical condition. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Visits to out-of-network emergency rooms for emergency services and supplies are covered at in-network levels, and in-network cost shares apply.

Emergency care for mental health conditions or substance use disorders may be provided by a facility and staff credentialed to provide behavioral health crisis services. Coverage also includes Mobile Crisis Response Services and support and stabilization services provided in a Residential Crisis Stabilization Unit or Crisis Receiving Center to the same extent that such services are covered in other settings or modalities. The plan does not require prior authorization for Emergency or crisis services.

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

- "Crisis Receiving Center" means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, and crisis stabilization services.
- "Mobile Crisis Response Services" means services licensed by the Department of Behavioral Health and Developmental Services to provide for rapid response to, assessment of, and early intervention for, individuals experiencing an acute mental health crisis that are deployed at the location of the individual.
- "Residential Crisis Stabilization Unit" means a community-based, short-term residential program licensed by the Department of Behavioral Health and Developmental Services to provide short-term assessment, observation, support and crisis stabilization for individuals who are experiencing an acute mental health crisis.

Enteral Nutrition

Benefits are provided for partial or exclusive feeding of specialized enteral formulas, administered either orally or by tube feeding as a critical source of nutrition, for certain conditions, including an inherited metabolic disorder, metabolic diseases, or severe food allergies, when administered under medical supervision, which may include a home setting. Coverage also includes any medical equipment, supplies, and services that are required to administer the covered formula and enteral nutrition products.

Benefits also include special food products or supplements when prescribed by a Physician and Medically Necessary. Benefits also include any liquid or solid formulation of formula and enteral nutrition products for a Covered Person requiring treatment for an inherited metabolic disorder.

An inherited metabolic disorder is an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Medically Necessary formula and enteral nutrition products are covered as medicine on the same terms and subject to the same conditions imposed on other medicines covered under this Policy.

Eyeglasses for Disease or Injury

Benefits for prescription eyeglasses or contact lenses when required as a result of Injury or disease. Benefits include exams related to the surgery or Injury.

Benefits are limited to the purchase and fitting of eyeglasses or contact lenses, or replacement thereof when required as a result of surgery or for the treatment of an accidental injury when:

- prescribed to replace the human lens lost due to surgery or injury,

SAMPLE

- when “pinhole” eyeglasses are prescribed for use after surgery for a detached retina, and
- for purchase and fitting of contact lenses when prescribed in place of surgery for the following:
- Contact lenses are used for the treatment of infantile glaucoma;
- Corneal or scleral lenses are prescribed in connection with keratoconus;
- Scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate;
- Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Benefits are provided only as described above. Examples of excluded items include, but are not limited to:

- Sunglasses or safety glasses and accompanying frames of any type;
- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- Any lost or broken lenses or frames if the person has already received benefits during a Benefit Period;
- Any blended lenses (no line), oversize lenses, or any frame in which the manufacturer has imposed a no discount policy.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician, including continuous hormone replacement therapy, outpatient lab testing to monitor hormone replacement therapy, and gender reassignment surgeries. Covered medical and behavioral health services may not be denied solely because the diagnosis is gender dysphoria. Benefits for gender dysphoria counseling are provided under Mental Health Care and Substance Related and Addictive Disorders Services.

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. One example would be therapy by a licensed therapist for a child who is not walking or talking at the expected age. 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, including services necessary to relieve pain; teach, keep, or improve function; prevent disability after illness, Injury, or loss of limb, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices; and treatment of lymphedema.
- Occupational therapy, including services necessary to teach, keep, or improve a person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy, including services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment; therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age; and services to identify, assess, and treat speech, language, and swallowing disorders in children and adults.
- Post-cochlear implant aural therapy.
- Cognitive therapy.
- Manipulative Treatment as described under *Manipulative Treatment*.
- Chiropractic services and osteopathic services. These therapies are similar but differ as follows:

  Chiropractic therapy focuses on the joints of the spine and the nervous system

  Osteopathic therapy focuses on the joints and surrounding muscles, tendons and ligaments.

SAMPLE

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 Medically Necessary, 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.*

Benefits are limited as follows:

- Speech therapy is limited to 30 visits per year.
- Manipulative therapy is limited to 30 visits per year.
- Any combination of physical therapy and occupational therapy is limited to 30 visits per year,

The limits for physical, occupational, and speech therapy will not apply if care is received as part Hospice Care, Early Intervention Services, Autism Spectrum Disorder, Mental Health Care and Substance-Related and Addictive Disorders Services. When you receive physical, occupational or speech therapy in the home, the home health care visit limit will apply instead of the above therapy services limits.

Benefits related to Early Intervention Services as required by Virginia law include Benefits for speech and language therapy, occupational therapy, and physical therapy for Enrolled Dependent children from birth to age three who are certified by the *Department of Behavioral Health and Developmental Services* as eligible for services under *Part C of the Individuals with Disabilities Education Act* (*20 U.S.C. s1471 et seq.*).

Note: Habilitative services may include physical and occupational therapy, medical devices, assistive technology services and devices, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention Services benefit.

SAMPLE

Hearing Aids

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

Benefits are available for a Hearing Aid and related services for children 18 years of age or younger when recommended. Such recommended services and equipment may be provided or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist. Coverage includes one Hearing Aid per hearing-impaired ear, up to a cost of $1500, every 24 months.

Benefits also include earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

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

Cochlear implants are not hearing aids. Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under 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 in the home or through remote patient monitoring 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, home health therapist, or licensed practical nurse and supervised by a registered nurse.
- Provided on an 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.

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

Examples of covered services include:

- Durable Medical Equipment and medical supplies provided in the home health care setting.
- Infusion Therapy.
- Diagnostic and social services.
- Nutritional guidance.
- Training.
- Physical therapy, speech therapy, and occupational therapy services.

In accordance with Virginia law, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care. Such visits are not subject to any applicable annual maximums described in the *Schedule of Benefits* under *Home Health Care*.

Private Duty Nursing

Medically skilled services of a licensed registered nurse (RN) or licensed practical nurse (LPN) provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us

SAMPLE

that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. 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:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- 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.
- Palliative care of pain and other symptoms that are part of a terminal illness. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Benefits for Palliative Care services are provided under the corresponding Benefit category in this Policy.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person’s primary caregiver a temporary break from caregiving responsibilities.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, and speech therapy; when provided under this benefit, these services are not subject to the visit limits described under *Habilitative Services* or *Rehabilitation Services – Outpatient Therapy.*
- Respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of the Covered Person's condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Covered Person's death. Bereavement services are available to surviving members of the Covered Person's immediate family for one year after the Covered Person's death. (Immediate family means the Covered Person's spouse, children, stepchildren, parents, brothers, and sisters.)

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 including, but not limited to:
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Lab and radiology/X-ray.
- Mammography.
- Ultrasounds.
- Pathology services.
- EEG and EKG services.
- Echocardiograms.

SAMPLE

Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).

Sleep testing. Benefits for any resulting Medically Necessary sleep treatment are available and will be provided based on where the Covered Care Health Service is provided (i.e., *Physician's Office Services - Sickness and Injury, Durable Medical Equipment (DME), Orthotics, and Necessary Medical Supplies*, etc.) as stated under each applicable category in this section (*Section 1*).

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.
- Professional services for test interpretation for lab and x-ray reading.
- Tests ordered before a surgery or hospital admission.
- Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services.
- PET/CT Fusion Scans, CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.
- Room and board in a Semi-private Room (a room with two or more beds). The most the plan will cover for a private room is the Hospital’s semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- Physician services for radiologists, anesthesiologists, pathologists and Emergent ER Services Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- A minimum Inpatient Stay of at least 48 hours following a radical or modified radical mastectomy and at least 24 hours following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.
- A minimum Inpatient Stay of at least 23 hours for a laparoscopy-assisted vaginal hysterectomy and at least 48 hours for a vaginal hysterectomy.
- Inter-hospital transfer for newborn or mother without Prior Authorization, when Medically Necessary transfer is required due to a newborn or mother experiencing a life-threatening emergency condition.
- Blood and blood products.
- Other invasive procedures such as angiogram/arteriogram, amniocentesis, tap or puncture of brain or spine.
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Treatment of fractures and dislocation.
- Pre-operative and post-operative care.
- Supplies and equipment, such as hypodermic needles, syringes, surgical dressings, splints, etc.

Benefits for the following are described in the indicated provisions:

- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery under *Reconstructive Procedures*.
- General anesthesia for dental care under *Dental Anesthesia and Services for Medical Treatments*.

Lab, X-Ray and Diagnostic Services 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.

SAMPLE

- Ultrasounds.
- Pathology services.
- EEG and EKG services.
- Echocardiograms.
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).
- One routine Prostate Cancer Screening including a Prostate Specific Antigen (PSA) test and digital rectal exam, or an equivalent serological test for a male per calendar year, and for additional PSA tests, if recommended by a Physician.

  Coverage for Prostate Cancer Screenings provided without cost share for Covered Persons:

  - Age 50 or older; or
  - Age 40 and older with a high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society
- Sleep testing. Benefits for any resulting Medically Necessary sleep treatment are available and will be provided based on where the Covered Care Health Service is provided (i.e., *Physician's office Services-Sickness and Injury, Durable Medical Equipment (DME), Orthotics, and Necessary Medical Supplies*, etc.) as stated under each applicable category in this section *(Section 1*).

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.
- Professional services for test interpretation for lab and x-ray reading.
- Tests ordered before a surgery or hospital admission.
- Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services.

PET/CT Fusion Scans, 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, PET/CT Fusion scans, MRI, MRA, MRS, CTA, SPECT scan, QCT Bone Densitometry, diagnostic CT colonography, nuclear cardiology, 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:

SAMPLE

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

Manipulative Treatment

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

Benefits are also provided for chiropractic and osteopathic therapies. These therapies are similar but differ as follows:

- Chiropractic therapy focuses on the joints of the spine and the nervous system;
- Osteopathic therapy focuses on the joints and surrounding muscles, tendons and ligaments.

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. Manipulative therapy is limited to 30 visits per year. The limit applies separately for rehabilitative and habilitative services.

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 Use Disorders Services coverage is provided for Covered Persons inclusive of children, adolescents, and adults. Benefits will be in parity with the medical and surgical benefits contained in this Policy in accordance with the Federal Mental Health Parity and Addiction Equity Act.

"Generally accepted standards of mental health or substance use disorder care" and "medically necessary" will be applied for all medical necessity, prior authorization and utilization review determinations under the coverage provided for Mental Health Care and Substance User Disorders Services.

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

- “Generally accepted standards of mental health or substance use disorder care” include peer-reviewed scientific studies and medical literature, consensus guidelines and recommendations of nonprofit health care provider professional associations and specialty societies, and nationally recognized clinical practice guidelines, including patient placement criteria, service intensity assessment instruments, clinical practice guidelines, guidelines and recommendations of federal government agencies, and drug labeling approved by the U.S. Food and Drug Administration.
- "Medically Necessary" means, with respect to the treatment of mental health or substance use disorder, a service or product addressing the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating such disorder, including minimizing the progression of such disorder, in a manner that is in accordance with generally accepted standards of mental health or substance use disorder care; clinically appropriate in terms of type, frequency, extent, site, and duration; and not defined primarily for the economic benefit of an insurer or purchaser or for the convenience of the patient, treating physician, or other health care provider.

Benefits include the following levels of care:

- Inpatient treatment. For Substance-Related and Addictive Disorders, eating disorders, and the like, inpatient services must be provided in a Hospital or treatment Facility that is licensed to provide a continuous, structured program of treatment and Rehabilitation, including 24-hour-a-day nursing care. Individualized and intensive treatment includes observation and assessment by a psychiatrist at least weekly and Rehabilitation, therapy, education, and recreational or social activities.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.

SAMPLE

- Intensive Outpatient Program for the treatment of Mental Health Care and Substance-Related and Addictive Disorders.
- Outpatient treatment - coverage is provided for office visits, outpatient facility and physician charges.
- 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, including psychological testing, psychotherapy and group psychotherapy.
- Family therapy, including counseling with covered family members to assist with the patient's diagnosis and treatment. Benefits also include detoxification, and rehabilitation treatment. Including Hospital and inpatient professional charges in any hospital or Facility required by state law.
- Electroconvulsive therapy (ECT).
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Services at a Residential Treatment Facility.

Services received from a Psychiatrist, Psychologist, Neuropsychologist, LCSW, Clinical Nurse Specialist, Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC) or any agency licensed by the state to give these services are covered.

In-person consultation is not required between a Physician and a Covered Person for services to be appropriately provided through Telehealth. Services provided by Telehealth are subject to the same terms and conditions of the Policy as any service provided via an in-person consultation.

Necessary Medical Supplies

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

Benefits are available for catheters and for necessary medical supplies furnished by a Provider that are used once, such as syringes, needles, surgical dressings, splints, etc.

Orthotics

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

Orthotic braces, customized or surgical grade boots, and splints (other than foot orthotics), including needed changes to shoes to fit braces, braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

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

Pediatric Autoimmune Neuropsychiatric Disorders

Benefits for the prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including the use of antimicrobials, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. The five criteria of PANDAS are usually accompanied by similar comorbid symptoms as found in PANS.

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

"Pediatric acute-onset neuropsychiatric syndrome (PANS)" means clinically defined disorder characterized by the sudden onset of obsessive-compulsive symptoms (OCD) or eating restrictions, concomitant with acute behavioral deterioration in at least two designated domains. Comorbid PANS symptoms may include anxiety, sensory amplification or motor abnormalities, behavioral regression, deterioration in school performance, mood disorder,

SAMPLE

urinary symptoms, or sleep disturbances. PANS does not require a known trigger, although it is believed to be triggered by one or more pathogens.

"Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)" means a subset of PANS that has five distinct criteria for diagnosis, including (i) abrupt “overnight” OCD or dramatic, disabling tics; (ii) a relapsing-remitting, episodic symptom course; (iii) young age at onset; (iv) presence of neurologic abnormalities; and (v) temporal association between symptom onset and Group A streptococcal infection.

Pharmaceutical Products - Outpatient

Pharmaceutical Products, including injectable drugs and new pharmaceutical products, for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home. Coverage also includes injections administered at an authorized pharmacy. For information on blood products, refer to *Therapeutic Treatments - Outpatient*.

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

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

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 copayment, at the same rate as a Designated Dispensing Entity.

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

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

Services provided in a Physician's or Specialist'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 retail health clinic (walk-ins) or located in a Hospital. Benefits include services for routine care provided by a nurse practitioner or any other advance practice registered nurse or a physician assistant.

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:

- A medical consultation with a Physician using the internet by webcam, chat, or voice. Online visits do not include reporting normal lab or test results; requesting an appointment; discussing billing, insurance, or payment issues; requesting a referral; benefit precertification; or your Physician's discussions with another Physician.
- Remote Patient Monitoring Services 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. Collection and analysis of patient physiologic data must be used to develop and manage the treatment plan for an acute or chronic illness or condition.
- Genetic Counseling.
- Allergy injections, allergy testing and treatment, and allergy serum.

SAMPLE

- Medical nutrition therapy provided by a licensed dietician or nutritionist working in coordination with a Physician to treat a chronic illness or condition.
- Infusion Therapy.
- Physician house calls as described under *Physician Fees for Surgical and Medical Services*.
- Diagnosis, treatment and correction of the underlying causes of infertility. Depending on where a service is administered, Benefits will be provided under the corresponding Benefit category in this Policy.

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

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

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

Pregnancy - Maternity Services

For a Covered Person or Dependent who becomes pregnant, Benefits for Pregnancy include all maternity-related medical services (including maternity-related checkups, and coverage of aspirin for the prevention of pre-eclampsia) for prenatal care, postnatal care, delivery (including delivery room and care and anesthesia services), routine nursery care during the mother's hospital stay, any related complications, including complications for which hospitalization is necessary, and miscarriage. Benefits are provided for Covered Health Care Services for delivery provided by a certified nurse midwife in a birthing center or home setting.

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

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

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

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

Benefits also include:

- Pregnancy testing.
- Folic acid supplements and expanded tobacco intervention and counseling for pregnant users.
- Circumcision of a covered male Dependent.
- Syphilis screening.

The following screenings for pregnant women are also covered:

- Anemia.
- Gestational diabetes.
- Hepatitis B.
- Rh incompatibility.
- Urinary tract or other infection.

The following fetal screenings are also covered:

- Genetic and/or chromosomal status of a fetus.
- Anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.

Breastfeeding/lactation counseling, certain screenings, and one breast pump per Pregnancy in conjunction with childbirth are covered under *Preventive Care Services* and are exempt from cost sharing.

SAMPLE

Benefits for postpartum care also include inpatient or home visits for the mother in accordance with the most current version of the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetrics and Gynecologists.

Postnatal care for the baby includes:

- Behavioral assessments and measurements.
- Screenings for blood pressure, hemoglobinopathies, hypothyroidism, and PKU.
- Infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Benefits will include any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
- Gonorrhea prophylactic medication.

If you are pregnant on the effective date of this Policy and in the first trimester of the Pregnancy, you must receive services from a Network Provider for the obstetrical care to be Covered Health Care Services. If you are pregnant on the effective date of this Policy and in your second or third trimester of Pregnancy (13 weeks or later) as of the effective date, Benefits for obstetrical care will be available at the in-network level even if the provider is not a Network Provider if you notify us by calling the telephone number listed on your ID card. Benefits for the obstetrical care will continue through the end of the Pregnancy and the normal postpartum period.

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, without cost-share, 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 also include:

- Infant hearing screenings.
- Screenings for abdominal aortic aneurysm, alcohol misuse, anxiety, colorectal cancer, high blood pressure, pre-diabetes/Type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, latent tuberculosis, lung cancer, obesity, syphilis, and tobacco use. Counseling for alcohol misuse, nutrition, obesity, and sexually transmitted infection prevention.
- Smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription (refer to the *Outpatient Prescription Drugs* section of this Policy).
- Aspirin and statins used to prevent cardiovascular disease (which are covered under the *Outpatient Prescription Drugs* section of this Policy).
- Preventive colonoscopy and related laboratory tests, including follow-up colonoscopy following a positive non-invasive stool-based screening test or direct visualization screening test. Benefits also include polyp removal and anesthesia provided in connection with a preventive screening colonoscopy.

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*. Benefits include assessments for alcohol and drug use, behavioral, oral health risk; medical history; BMI measurements; screenings for autism (18 and 24 months), anxiety, blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision. Also includes counseling for obesity and STI. Benefits also include prescription fluoride chemoprevention supplements for children ages 0 - 16 (which is covered under the *Outpatient Prescription Drugs* section of this Policy).

With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include:

- Well woman visits.

SAMPLE

- Diagnostic Breast Examinations and Supplemental Breast Examinations (as defined in *Section 8: Defined Terms*), including but not limited to, diagnostic mammography, MRI, 3D mammography, pathology evaluation, and ultrasound.
- Patient-collected hrHPV testing for women age 30 - 65 at average risk and additional testing, if required, to complete the screening process and follow-up findings.
- Screenings for urinary incontinence, diabetes screening after gestational diabetes, BRCA risk assessment and genetic testing, cervical cancer, intimate partner and domestic violence, HPV, HIV, sexually transmitted infections (STIs), PrEP HIV medication, and osteoporosis.
- Counseling for breast cancer genetic testing (BRCA), breast cancer chemoprevention, domestic and interpersonal violence, and sexually transmitted infections (STIs).

Contraceptive methods and counseling: Coverage includes the full range of Food and Drug Administration approved, cleared, or granted contraceptive methods, including drugs, injectable, patches, rings, diaphragms, IUDs, implants, and sterilization procedures including associated anesthesia for adolescent and adult women; at least one form of contraception under every method listed in the HRSA-supported guidelines is covered without cost sharing. Also contraceptives available over-the-counter, as covered under the *Outpatient Prescription Drugs* section of this Policy. This includes the screenings needed for the management and evaluation of the contraceptive product or service, insertion or removal of contraceptive devices, and any Medically Necessary consultations, examinations, or procedures associated with the use of intrauterine devices, diaphragms, injectable contraceptives, and implanted hormonal contraceptives. If the Covered Person's health care provider determines a particular contraceptive is medically appropriate for that person, benefits will be provided without cost-sharing. Benefits also include the clinical services, including patient education and counseling, needed for the provision of the contraceptive product or services, and items that are integral to the furnishing of the recommended preventive service, regardless of whether the item or service is billed separately.

Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.

Mammography including low-dose mammograms at certain age intervals. Benefits include a baseline mammogram for women 35 to 39 years of age, one such mammogram biennially to persons age 40 through 49, one such mammogram annually to persons age 50 and over.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include breast feeding/lactation counseling and one breast pump per Pregnancy in conjunction with childbirth. This Benefit includes a personal-use electric breast pump, including a double electric pump, pump parts and maintenance, and breast milk storage supplies. 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.

For more information about preventive care services, you may view the federal government's web sites at (Preventive health services | HealthCare.gov), (A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)), and (Preventive Guidelines and Screenings for Women, Children, and Youth | MCHB (hrsa.gov)).

Prosthetic Devices

Covered Services include benefits for prosthetic devices and components when determined by peer- reviewed medical literature to be medically appropriate based on the clinical assessment of your rehabilitation potential. A prosthetic device includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, hand, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Covered Services may include, but are not limited to:

- Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device).
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women’s Health and Cancer Rights Act.

SAMPLE

- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis)
- Wigs needed after cancer treatment. Minimum Requirement: One wig per Benefit Period.

Ostomy supplies may include, but are not limited to the following:

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

Reconstructive Procedures

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

- Correction of congenital abnormalities that cause functional impairment.
- Newborn congenital deformities caused by congenital or developmental abnormalities, disease, trauma or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.
- 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 in both an outpatient and inpatient setting. Coverage includes procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.

Cosmetic Procedures are excluded from coverage.

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

Cleft Lip and Cleft Palate Treatment

Coverage for inpatient and outpatient dental, oral surgical, and orthodontic services for the treatment in connection with cleft lip, cleft palate, or ectodermal dysplasia. Services must be provided under the direction of a Physician. Benefits also include dental services and dental appliances to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy, including services to relieve pain; teach, keep, improve or restore function; prevent disability after illness, Injury, or loss of limb, including hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices; and treatment of lymphedema.
- Occupational therapy, including services to teach, keep, improve or restore a person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.
- Speech therapy, including services necessary to teach speech and therapy to develop communication or swallowing skills to correct a speech impairment; therapy to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age; and services to identify, assess, and treat speech, language, and swallowing disorders in children and adults.
- Pulmonary Rehabilitation Therapy, including outpatient short-term respiratory care following an illness or Injury.

SAMPLE

- Cardiac rehabilitation therapy, including medical evaluation, training, supervised exercise, and psychosocial support following a cardiac event. Services will not be provided for home programs (other than home health care services), on-going conditioning, and maintenance care.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Manipulative Treatment as described under *Manipulative Treatment*.

Benefits are limited as follows:

- Speech therapy is limited to 30 visits per year.
- Manipulative therapy is limited to 30 visits per year.
- Pulmonary and Cardiac therapy are not subject to visit limits.
- Any combination of physical therapy and occupational therapy is limited to 30 visits per year,

The limits for physical, occupational, and speech therapy will not apply if care is received as part Hospice Care, Early Intervention Services, Autism Spectrum Disorder, Mental Health Care and Substance-Related and Addictive Disorders Services. When you receive physical, occupational or speech therapy in the home, the home health care visit limit will apply instead of the above therapy services limits.

To be Covered Health Care Services, rehabilitation services must involve goals that can be reached in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and the Covered Person stops progressing toward those goals.

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:

SAMPLE

- Supplies and non-Physician services received during the Inpatient Stay, including Medically Necessary drugs and biological drugs/products.
- Room and board in a Semi-private Room (a room with two or more beds). Benefits are available for a private room only when Medically Necessary.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Skilled convalescent care.
- Inpatient rehabilitative 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, including pre-operative and post-operative care and related services, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Benefits for ancillary services include anesthesia, anesthesia supplies and services given by the Hospital or other Provider.

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

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.
- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.
- Surgical correction of oral and maxillofacial accidental injuries.

Benefits include coverage for certain invasive procedures. Examples of invasive procedures include:

- Treatment of fractures and dislocation.
- Angiogram/Arteriogram.
- Amniocentesis.
- Tap or puncture of brain or spine.

Benefits include:

- The Facility charge and the charge for supplies and equipment, such as hypodermic needles, syringes, surgical dressings, splints, etc.
- Blood and blood products.
- Cataract surgery with a standard intraocular lens.
- Surgical implantation of cochlear implants or other implantable hearing devices when you have either of the following:

SAMPLE

- 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.

- 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.).
- Abortion when the mother's life is endangered or when the Pregnancy is the result of an alleged act of rape or incest.
- Voluntary male sterilization, including associated anesthesia. (Female sterilization is covered under the *Preventive Care* benefit category.)
- Reversal of a non-elective sterilization that was the result of a Sickness or Injury.

Benefits also include maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy related to tooth extraction; orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone that is medically necessary to attain functional capacity of the affected part; correction of accidental injuries; surgical services on the hard or soft tissue of the mouth for purposes not related to treat or help teeth and supporting structures; removal of tumors, treatment of non-dental lesions; biopsies; incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. Treatment of cleft lip, cleft palate, or ectodermal dysplasia.

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

Benefits for the following are described in the indicated provisions:

- Procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery under *Reconstructive Procedures*.
- General anesthesia for dental care under *Dental Anesthesia and Services for Medical Treatments*.

Telehealth

Benefits are provided for diagnosis, consultation, or treatment of covered services delivered via interactive Telehealth/Telemedicine, such as audio, video, or other electronic technology or other media (other than audio-only telephone, email, fax, or online questionnaire). 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 online visits by webcam, chat, or voice of a Physician-patient encounter from one site to another using telecommunications technology, including Remote Patient Monitoring Services, regardless of the originating site and whether the Covered Person is accompanied by a health care provider at the time services are provided. 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)

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders when treatment is needed for diagnostic, medical, 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 treatment of temporomandibular joint and craniomandibular disorders.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.

Benefits for non-surgical treatment of temporomandibular joint and craniomandibular disorders include intra-oral splints.

SAMPLE

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, including home intermittent peritoneal dialysis, home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis). Home equipment, supplies, and training for acute and chronic (end-stage) renal disease are also covered Benefits.
- Training for you and the person who will help you with home self-dialysis.
- Intravenous Chemotherapy or other intravenous Infusion Therapy.
- Radiation oncology, including but not limited to, treatment by x-ray, radium, or radioactive isotopes. Also includes materials and supplies, administration, treatment planning, and other covered services, such as teletherapy, brachytherapy, and interoperative radiation, photon, or high energy particle sources.
- Blood and the administration of blood products and blood infusion equipment required for the outpatient or home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. A home treatment program must be under the supervision of a state-approved hemophilia treatment center. "State-approved hemophilia treatment center" means a Hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.
- The Facility charge and the charge for related supplies and equipment including those related to lymphedema.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

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.

Therapy visit limits do not apply for chemotherapy and radiation therapy given as palliative care.

In accordance with Virginia law, cost-sharing (Co-payments, Co-insurance or Deductible amounts) for orally administered chemotherapy drugs and cancer chemotherapy drugs shall not be greater than cost-sharing for such drugs administered intravenously or by injection.

Transplantation Services

Organ, tissue, and stem cell/bone marrow transplants and infusions, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service.

Examples of transplants for which Benefits are available include:

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

SAMPLE

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

Benefits include Medically Necessary transfusions, acquisition procedures (including benefits provided to the donor for the costs of organ removal from a living donor, including complications from the donor procedure for up to six weeks following the date of procurement), mobilization, harvest and storage, and preparatory myeloablative therapy, reduced intensity preparatory chemotherapy, radiation therapy, or a combination of these therapies.

Reimbursement for reasonable and necessary transportation and lodging costs for the Covered Person receiving care and a companion are covered, or for two companions if the Covered Person receiving care is a minor, when the Covered Person gets prior approval and needs to travel more than 75 miles from his or her permanent home to reach the Facility where the covered transplant procedure will be performed. Benefits will be covered up to the current limits set forth in the Internal Revenue Code.

Reimbursement for reasonable and necessary transportation and lodging costs for the donor are covered when the recipient and donor are covered under the same Policy. Benefits may be limited if only the recipient is covered under the Policy.

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

Urgent Care Center Services

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

The following exclusions do not apply to Benefits for pediatric dental care as described in *Section 11: Pediatric Dental Care Services*.

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.

SAMPLE

- The direct treatment of cancer or cleft palate.
- Dental anesthesia for which Benefits are provided as described under *Dental Anesthesia and Services for Medical Treatments* 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).

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, except for which Benefits are described under *Prosthetic Devices* in *Section 1: Covered Health Care Services*.

SAMPLE

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. See the *Outpatient Prescription Drugs* section of this Policy for prescription drug products covered under the pharmacy benefit.
2. Self-administered or self-infused medications that are covered under the *Outpatient Prescription Drugs* section 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. This exclusion also does not apply to self-administered injectable Prescription Drug Products that are covered under the *Outpatient Prescription Drugs* section of this Policy.
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. This exclusion does not apply to over-the-counter drugs required to be covered under federal law when recommended by the U.S. Preventive Services Task Force and whether or not prescribed by a Physician.
5. Growth hormone therapy.
6. 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.
7. 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.

Experimental or Investigational Services

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

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

Foot Care

1. Routine foot care. Examples include:

Cutting or removal of corns and calluses.

Nail trimming, nail cutting, or nail debridement.

Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to treatment of corns, calluses, and care of toenails that is Medically Necessary.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Foot orthotics, orthopedic shoes, inserts, modifications, and footwear, unless Medically Necessary.
5. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings. This exclusion does not apply to supplies for which Benefits are described in *Necessary Medical Supplies* in *Section 1: Covered Health Care Services*.

SAMPLE

- Items routinely found in the home.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME)* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.*
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.

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

Nutrition

1. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula and special food products or supplements 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 under *Physician's Office Services* in *Section 1: Covered Health Care Services*.

Personal Care, Comfort or Convenience

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

SAMPLE

- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

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

SAMPLE

- Lip augmentation.
- Lip reduction.
- Mastopexy.
- 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.

This exclusion does not apply to:

- Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
- Surgery or procedures to correct congenital abnormalities that cause functional impairment.
- Surgery or procedures on newborn children to correct congenital abnormalities.
- Medically Necessary benefits determined according to nondiscriminatory criteria that are consistent with current medical standards.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as 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. Medical and surgical treatment of excessive sweating (hyperhidrosis).
2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. 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.
4. Biofeedback.
5. Surgical treatment of obesity.
6. Breast reduction and augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine treats a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

Providers

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

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 diagnosis and treatment of any underlying cause of infertility.
2. The following services related to a Gestational Carrier or Surrogate:

SAMPLE

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

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

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat sexual dysfunction and/or impotency.
8. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage) This exclusion does not apply to therapeutic abortion recommended by a doctor and performed to save the life of the mother or as a result of incest or rape.

Services Provided Under Another Plan

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

SAMPLE

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 as described in *Transplantation Services* in *Section 1: Covered Health Care Services.* 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.* Travel costs: mileage, lodging, meals, and other Covered Person-related travel costs except as described in the medical Schedule of Benefits.

Types of Care, Supportive Services, and Housing

1. Custodial Care or maintenance care.
2. Domiciliary care.
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. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).
7. Private Duty Nursing. This exclusion does not apply to Covered Health Care Services for which Benefits are provided as described under *Home Health Care* in *Section 1: Covered Health Care Services*. Private Duty Nursing services in an Inpatient setting remain excluded.

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to services for which Benefits are provided as described under *Eyeglasses for Disease or Injury* in *Section 1: Covered Health Care Services* and in *Section 12: Pediatric Vision Care Services*.
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to benefits for routine vision exams as described in *Section 12: 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. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
2. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
3. Transitional Living (including recovery residences).
4. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
5. Services provided in unlicensed, and, or non-accredited program. Treatment or services that are non-professionally directed.
6. 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.

SAMPLE

- 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*.

7. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under this *Policy* when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
8. 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.
9. 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.
10. 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.
11. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
12. 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.
13. Autopsy.
14. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
15. 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.
16. Proprietary Laboratory Analysis drug testing are not a covered service (such as U codes).
17. Blood or tissue typing for paternity testing are not a covered service.
18. Specimen Provenance testing are not a covered service.
19. Services or supplies for teaching, vocational, or self-training purposes, except as specifically provided in *Section 1: Covered Health Care Services*.

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SAMPLE

20. Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.
21. Stand-by availability of a medical practitioner when no treatment is rendered.
22. 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 Virginia Insurance Exchange Marketplace. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

Who Is Eligible for Coverage?

The Virginia Insurance Exchange 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 Virginia Insurance Exchange 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 Virginia Insurance Exchange 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 Virginia Insurance Exchange Marketplace.

Coverage begins on the date determined by the Virginia Insurance Exchange 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 Virginia Insurance Exchange Marketplace. As of March 1, 2025, Virginia considers pregnancy a Qualifying Life Event.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Virginia Insurance Exchange Marketplace.

SAMPLE

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

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

Premiums

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

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

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

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

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

(Note that Benefits for Outpatient Prescription Drugs, Adult Vision Care Services, Adult Dental Care Services, Pediatric Vision Care Services, and Pediatric Dental Care Services, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.)

Change or Misstatement of Residence

If you change your residence, you must notify Virginia Insurance Exchange Marketplace of your new residence. Your Premium will be based on your new residence beginning on the date determined by Virginia Insurance Exchange 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 payment of a pro rata premium for the time the Policy was in force during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We will 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 pro rata Premium due from you by the end of the grace period.

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. Claims will be pended for claims incurred for services received during the second and third months 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 75 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.

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).

CANCELLATION BY INSURED

The Covered Person may cancel this Policy at any time by written notice delivered to us or mailed to our administrative office. Cancellation shall be effective upon receipt of such notice by us, or on a later date specified in the notice.

Upon cancellation, we shall return promptly the unearned portion of any Premium paid. The earned Premium shall be computed on a pro rata basis.

Cancellation of this Policy shall be without prejudice to any claim originating prior to the effective date of cancellation.

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.

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 Virginia Insurance Exchange 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 Virginia Insurance Exchange 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**

SAMPLE

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

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

We will provide advance notice of when coverage ends, except for terminations due to non-payment of premiums or a change in eligibility status.

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. We will provide at least 31 days advance written notice if coverage ends due to non-payment of premiums.

- **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. You have the right to a refund of all premiums paid less any claims paid beyond the date on which coverage ends.

  The 30 days advance notice will include:

Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of material fact;

Notice that you or your authorized representative, prior to the date the advance notice ends of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;

A description of our internal appeal process for rescissions, including any time limits applicable to those procedures; and

The date when the advance notice ends and the date back to which the coverage will be rescinded.

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.

SAMPLE

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 Virginia Insurance Exchange Marketplace.

SAMPLE

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?

Notice of Claim

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

Claim Forms and Proof of Loss

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

Required Information

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

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

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

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

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Payment of Claims

Time for Payment of Claim

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

Assignment of Benefits

When Benefits are assigned to a provider of covered ambulance services, we will pay the provider directly. When Benefits are assigned to a provider of Covered Health Care Services who is a dentist or oral surgeon, we will pay the provider directly.

SAMPLE

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. 116-120)* are paid directly to the provider.

It is your responsibility to apply any payment received from us related to Services received from an Out-of-Network provider to the claim from the Out-of-Network 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.

SAMPLE

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 a letter or complete a Member Services Request Form from myuhc.com to file a complaint about quality of services and quality of care that you received.

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

How Do You Appeal a Decision?

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

Post-service Claims

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

Pre-service Requests for Benefits

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

Concurrent review requests are considered pre-service requests. "Concurrent review" means utilization review conducted during your stay or course of treatment in:

- A Facility;
- The office of a health care professional; or
- Other inpatient or outpatient health care setting.

SAMPLE

How to Request an Appeal

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

Your request for an appeal should include:

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

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

For Managed Care Health Insurance Plans (MCHIPs), if a covered person has verbally expressed a desire to file an appeal of an adverse benefit determination, the health plan will send the covered person the Virginia MCHIP Written Complaint Form. Once the completed form or a written appeal is received, the standard review process will begin.

Appeal Process

The internal review process will provide a full and fair review of any adverse benefit determination.

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

Appeal Determinations

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

Appeal Type	Response Time from Receipt of Request
Pre-service request for Benefit appeals	30 calendar days
Post-service claim appeals	60 calendar days

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure including our determination that a treatment, device, or pharmacological regimen is not covered because it is an Experimental or Investigational Service.

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

Concurrent Review Requests

Reduction or termination of approved treatment to be provided over time or over a number of treatments constitutes an adverse benefit determination. In such cases, we must notify you sufficiently in advance to allow you to file an internal appeal and obtain a determination before benefits are reduced or terminated.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

SAMPLE

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

We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If we need more information from you or your Physician to make a decision, we will notify you or your Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete our review. You or your Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. We will notify you and your Physician of the decision not later than 48 hours after the earlier of 1) our receipt of the specified information or 2) the end of the period afforded to provide the requested information. The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

For all other non-urgent review requests, see Pre-service Requests for Benefits and Post-service Claim Appeals above.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you or your Physician as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete our review. You or your Physician will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the requested information. We will notify you and your Physician of the decision not later than 48 hours after the earlier of 1) our receipt of the specified information or 2) the end of the period afforded to provide the requested information.

We will provide continued Benefits pending the outcome of an internal appeal of a concurrent review decision.

If you have requested an urgent internal appeal, you may also, at the same time, request an expedited external review when the appeal involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function. The process for submitting an expedited external appeal is described below under Expedited External Review.

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

Exhaustion of Internal Appeal Process

You must exhaust the internal appeal process before submitting a request for external review as described below under *Virginia External Review Program*. The internal appeal process is considered exhausted when:

You have completed the standard internal appeals process as described above under Pre-service *Requests for Benefits and Post-service Claim Appeals*.

You did not receive a decision from us within the required time frame concerning a standard internal appeal.

You have requested an urgent internal appeal as described under Urgent Appeals that Require Immediate Action, in which case you may also make a written or verbal request for an expedited external review (see *Expedited External Review* below).

We waived the requirement to exhaust the internal appeal process.

We violated Virginia internal appeal requirements, except where such violation is a "de minimus" violation, which means the violation does not cause, and is not likely to cause, prejudice or harm to you so long as we demonstrate that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange between you and us. You may:

Request written explanation of the violation from us, and we will provide written explanation within 10 calendar days of receipt of your request.

SAMPLE

Request *IRO* review to determine if we have violated Virginia internal appeal requirements. The *IRO* will provide a written response to you, us and the commission within 10 calendar days of receipt of your request. If rejected, within 5 calendar days we must notify you of your right to resubmit and pursue an internal appeal.

Office of the Managed Care Ombudsman/Office of Licensure and Certification

If you have any questions regarding the appeals processes outlined above or other grievances concerning health care coverage issues that have not been satisfactorily addressed by us, you may contact the *Office of the Managed Care Ombudsman* for assistance at any time as follows:

Office of the Managed Care Ombudsman

[P.O. Box 1157]

[Richmond, VA 23218]

Phone number: [(877) 310-6560]

Fax number: [(804) 371-9944]

E-mail: [Ombudsman@scc.virginia.gov]

In addition, if you have any questions regarding an appeal or grievance concerning provider quality of care issues that have not been satisfactorily addressed by the provider or your plan, you may contact the *Office of Licensure and Certification* for assistance at any time as follows:

[VDH Office of Licensure and Certification

ATTN: Complaint Unit

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1463

Telephone: (800) 955-1819 or (804) 367-2106

Fax: (804) 527-4503

E-mail: OLC-Complaints@vdh.virginia.gov]

Virginia External Review Program

If, after exhausting your internal appeals, as described above under *Exhaustion of Internal Appeal Process*, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination. This process is administered by the *Virginia Bureau of Insurance*. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons (the service, treatment or procedure does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness).
- The exclusions for Experimental or Investigational Services.
- As otherwise required by applicable law.
- An adverse determination relates to the treatment of cancer.

If you wish to appeal our final decision as described above, you or your representative may file a request for a standard external review in writing with the *Virginia Bureau of Insurance*. If, in urgent situations as detailed below, you wish to file a request for an expedited external review, you or your representative may do so by sending a written request to the *Virginia Bureau of Insurance's* address. We will provide to you, at the time a final adverse decision is reached, with a copy of the *Virginia Bureau of Insurance's* external review request form, which contains the address and information for requesting an external review.

An external review will be performed by an *Independent Review Organization (IRO*). There are two types of external reviews, standard and expedited.

SAMPLE

A request for a standard external review must be made within 120 calendar days after the FINAL adverse benefit determination is received and must include a general release for all medical records pertinent to the external review. An expedited external review in urgent situations may be requested as detailed below under Expedited External Review. If one of the following circumstances applies, you may request an external review prior to exhausting the internal appeal process:

- You did not receive a decision from us within the required time frame concerning a standard internal appeal.
- We waived the requirement to exhaust the internal appeal process.
- In the case of an expedited external review request, for the reasons described below under Expedited External Review.

If you have questions about the external review process, you may contact the *Virginia Bureau of Insurance* directly at:

Bureau of Insurance - External Review

P.O. Box 1157

Richmond, VA 23218

Telephone: (877) 310-6560

Fax: (804) 371-9915

E-mail: externalreview@ssc.virginia.gov

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the Virginia Bureau of Insurance.
- Assignment of an IRO by the Virginia Bureau of Insurance.
- A decision by the IRO.
- An adverse determination relates to the treatment of cancer.

Within five business days following receipt of your request from the *Virginia Bureau of Insurance*, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure was requested or provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, we will issue a notification in writing to you, your representative, if applicable, and the Virginia Bureau of Insurance. If the request is eligible for external review, the *Virginia Bureau of Insurance* will assign an *IRO* to conduct such review. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

The *Virginia Bureau of Insurance* will notify you in writing of the request's eligibility and acceptance for external review and provide the name of the assigned *IRO*. You may submit in writing to the IRO within five business days after the date you receive the IRO's external review additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after five business days.

We will provide the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.

SAMPLE

- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the IRO.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "Final External Review Decision") within 45 calendar days after it receives the request for the external review (unless they request additional time and you agree, except that, for a standard external review concerning Experimental or Investigational Services, the *IRO* will provide notice of the *Final External Review Decision* within 20 calendar days after the date it receives an opinion from all assigned clinical reviewers, who will have up to 20 calendar days to provide an opinion to the *IRO*). The *IRO* will deliver the notice of *Final External Review Decision* to you, your representative and us, and it will include the clinical basis for the determination.

If we receive of a *Final External Review Decision* reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

The written ruling of the *IRO* is final and binding on both you and us.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process. A Covered Person is not required to have exhausted his health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

You may make a written request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an urgent internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an urgent internal appeal.
- An adverse determination relates to the treatment of cancer.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request from the *Virginia Bureau of Insurance*, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure was requested or provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the *Virginia Bureau of Insurance* will assign an *IRO* in the same manner utilized to assign standard external reviews to *IROs*. We will provide all required documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The *IRO*, to the extent the information or documents are available, and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request except that, for an expedited external review concerning Experimental or Investigational Services, the *IRO* will provide notice of the final external review decision within 48 hours after the date it receives an opinion from all assigned clinical reviewers, who will have up to five calendar days to provide an opinion to the *IRO*. If

SAMPLE

the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to us.

The written ruling of the IRO is final and binding on both you and us.

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

SAMPLE

Section 7: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers?

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

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

What Is Your Relationship with Providers?

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

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable. You will not be responsible for an amount that exceeds the Allowed Amount if Covered Health Care Services are received from a Network provider, if Emergency Covered Health Care Services are received from an out-of-Network provider, if Emergency Air Ambulance services are received from an out-of-Network provider, or if Surgical or Ancillary Services are received at a Network Facility from an out-of-Network provider on a non-Emergency basis.
- 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.

SAMPLE

- 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 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 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 or Co-insurance as described in your *Schedule of Benefits*.

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

Do We Receive Rebates and Other Payments?

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

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

However, any exercise of such authority, whether by us or such other persons or entities, is subject to your rights of appeal and external review as described in *Section 6: Questions, Complaints and Appeals*.

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.

Any exercise of such discretion, whether by us or such other persons or entities, is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

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. For any change that amounts to a Benefit reduction, we will provide written notice of a benefit reduction sixty (60) days before it becomes effective. We will notify you of the change thirty (30) days prior to the effective date of the benefit

SAMPLE

reduction. Any exercise of such discretion is subject to your right of appeal and external review as stated in *Section 6: Questions, Complaints and Appeals*.

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

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

Amendments to this Policy are effective upon renewal, except as otherwise permitted by law.

- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Is Workers' Compensation Affected?

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

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are enrolled in Medicare may also be enrolled under the Policy.

If you are enrolled in Medicare, please read the following information carefully.

SAMPLE

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after proof of loss has been filed in accordance with the Policy. After completing that process, if you want to bring a legal action against us you must do so within three years of the date that proof of loss was required to be filed or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to such person's beneficiary or personal representative. All statements made by the Covered Persons shall be deemed representations and not warranties. A copy of any application shall be attached to the Policy when issued.

A provision that the Policy and any amendments to it constitutes the entire contractual agreement between the parties involved and that no portion of the charter, bylaws, or other document of the health maintenance organization shall constitute part of the Policy unless it is set forth in full in the Policy.

SAMPLE

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.

Reimbursement levels for Emergency Health Care Services and non-emergency services provided to at a Network Facility by an out-of-Network provider will be based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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.

Ambulance - a vehicle for Medically Necessary transportation of sick and/or injured persons that is equipped and staffed to provide medical care during transport.

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

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

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

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

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities. Autism Spectrum Disorder means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition, or the most recent edition at the time of diagnosis, of the *Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.

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

SAMPLE

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

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

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

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

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

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

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

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

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

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

Covered Pharmaceutical Product – a Pharmaceutical Product and/or new dosage form that is classified as a *U.S. Food and Drug Administration (FDA)*-approved prescription medication or product administered in connection with a Covered Health Care Service by a Physician.

This does not include 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.
- Is a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another Pharmaceutical Product.
- Is a Pharmaceutical Product with an approved biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another Covered Pharmaceutical Product.

For the purpose of this definition, 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.

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.

SAMPLE

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

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

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.

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

Designated Provider – a Network 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 as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures as shown in the *Schedule of Benefits* table within the applicable Covered Health Care Service category.

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 Network 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.

Diagnostic Breast Examination - a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including such an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate (i) an abnormality seen or suspected from a screening for the detection of breast cancer or (ii) an abnormality detected by another means of examination.

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 outside a medical facility.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Is of no further use to a person when medical need ends.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

SAMPLE

Early Intervention Services - speech and language therapy, occupational therapy, physical therapy, and assistive technology and devices. Early Intervention Services for the population certified by the Department are those services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment.

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

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

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

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and Facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to Stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided), and
- As it relates to Mental Health Care Services or Substance-Related and Addictive Disorders Services rendered at a behavioral health crisis service provider:
  - A behavioral health assessment that is within the capability of a behavioral health crisis service provider, including ancillary services routinely available to evaluate such emergency medical condition, and
  - Such further examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health crisis service provider, as are required so that the patient's condition does not deteriorate.
- 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 or Facility determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or Facility located within a reasonable distance taking into consideration the patient's medical condition.

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

  c) 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. Reimbursement levels for Emergency Health Care Services and non-emergency services provided at a Network Facility by an out-of-Network provider will be based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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

SAMPLE

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

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

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

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

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

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

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

Exceptions:

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

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

Facility - an institution providing health care related services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

SAMPLE

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

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

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

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

Habilitative services are limited to:

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

Hearing Aid – a wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing. Hearing Aid includes any parts, attachments, or accessories, including earmolds. Hearing Aid does not include batteries and cords. Hearing Aids are not considered to be Durable Medical Equipment.

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

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

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

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

Independent Freestanding Emergency Department - a health care Facility that:

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

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients. Infusion Therapy may include intra-muscular, subcutaneous, or continuous subcutaneous injections. Infusion Therapy includes:

- Nursing, durable medical equipment, and drugs delivered and administered by a health care provider as part of a Physician's visit, homecare visit, or at an outpatient Facility.
- Drug infusion therapy, blood products, and injectables that are not self-administered.
- Total Parenteral Nutrition (TPN) and enteral nutrition therapy.
- Antibiotic therapy.
- Chemotherapy.
- Pain care.

Infusion of special Medical Formulas as a critical source of nutrition for persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies.

SAMPLE

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 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 treatment over a period of three or more continuous hours per day to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

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

Medical Formulas - special medical formulas which are the primary source of nutrition for the Covered Person with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

Medically Necessary - health care services, that are all of the following as determined by us or our designee subject to the appeal rights described in *Section 6: Questions, Complaints and Appeals*.

- In accordance with *Generally Accepted Standards of Medical Practice* or generally accepted standards of mental disorder or condition care.
- Clinically appropriate, in terms of type, frequency, extent, and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- With regard to Benefits for diagnosis and treatment of Autism Spectrum Disorder, reasonably expected to do any of the following:
  - Prevent the onset of a Sickness, condition, Injury, or disability;
  - Reduce or ameliorate the physical, mental, or developmental effects of a Sickness, condition, Injury, or disability; or
  - Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Covered Person and the functional capacities that are appropriate for individuals of the same age.

SAMPLE

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

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

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

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

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

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.*

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.

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 or someone on your behalf pays, to the extent allowed by law, 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 that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or

SAMPLE

other drug dependence, who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Treatment shall be provided over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

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.

Pulmonary Rehabilitation Therapy -- Introduction into the lungs of dry or moist gases, nonpressurized inhalation; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, CPAP; CNP; chest percussion; therapeutic use of medical gases or aerosol drugs, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho pulmonary drainage and breathing exercises.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from the Virginia Insurance Exchange 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 Network Facilities for Surgical or Ancillary Services.

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

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

SAMPLE

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.

For Emergency Health Care Services provided to a Covered Person by an out-of-Network provider and for non-emergency services provided to a Covered Person at a Network Facility by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or the commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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 Patient Monitoring Services - the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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. It must meet all of the following requirements:

- Offers individualized and intensive treatment and includes: observation and assessment by a psychiatrist weekly or more often, rehabilitation, therapy, education, and recreational or social activities.
- Provides a program of treatment under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board – includes room and board in a Semi-private Room (a room with two or more beds).
  - Evaluation and diagnosis.
  - 24-hour per day nursing care.
  - 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. A description of the Service Area is provided to you at the time of enrollment.

SAMPLE

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.

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.

Stabilize - means, with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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*.

Supplemental Breast Examination - a medically necessary and appropriate, in accordance with the National Comprehensive Cancer Network Guidelines, examination of the breast, including such an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is (i) used to screen for breast cancer when there is no abnormality seen or suspected and (ii) based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

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

- Related to any professional services, including surgery, anesthesiology, pathology, radiology and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists; and
- Diagnostic services, including radiology and laboratory services.

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

Telehealth/Telemedicine - live, interactive online visits by webcam, chat, or voice of a Physician-patient encounter from one site to another using telecommunications technology, including Remote Patient Monitoring Services. 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.

SAMPLE

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

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

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. 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: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

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

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: liability insurance contracts or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In

SAMPLE

addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

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

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

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

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

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

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

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

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

         (a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a

SAMPLE

dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

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

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

The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

The services are provided in any Facility that is not eligible for Medicare reimbursements, including a Veterans Administration Facility, Facility of the Uniformed Services, or other Facility of the federal government. Medicare benefits are determined as if the services were provided by a Facility that is eligible for reimbursement under Medicare.

The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable.

Payments Made

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

SAMPLE

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

Does This Plan Have the Right of Recovery?

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

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

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

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Section 10: 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 Optimum Choice, 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*.

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

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 https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists/individual-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 will not be able to use your benefit coverage to fill the prescription.

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You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment or Co-insurance, and any deductible that applies.

Submit your claim to:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may not have coverage, unless the pharmacy, or its intermediary agrees in writing to accept reimbursement, including any copayment, coinsurance, or deductible amounts, at the same rate as the Designated Dispensing Entity.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, 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.

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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 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.

Benefits are provided for a Prescription Drug Product not approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed provided that:

The drug has not been approved by the USFDA for that specific type of cancer for which the drug has been prescribed, or a covered indication if the drug has been approved by the USFDA for at least one indication, If the drug has been recognized as safe and effective for the treatment of the specific condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Benefits are also provided for any Prescription Drug Product approved by the Food and Drug Administration (FDA) for use in the treatment of cancer even if the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. "Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier. "Standard reference compendia" means the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, or The United States Pharmacopoeia Dispensing Information.

However, Benefits for any Prescription Drug Product approved by the Federal Drug Administration (FDA) for use in the treatment of cancer pain are covered even if the dosage is exceeded if the prescription in excess of the dosage has been prescribed for a patient with intractable cancer pain.

Benefits for Oral Chemotherapeutic Agents -- Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient* in *Section 1 Covered Health Care Services*, regardless of tier placement.

Enteral Nutrition - Benefits are provided for Medical Formulas for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status.

Refill Synchronization -- Prescriptions dispensed by a network pharmacy for a partial supply of a covered prescription drug, in order to synchronize your medications, will be covered at a prorated cost-sharing rate.

If a non-Network Pharmacy or its intermediary has notified us or our intermediary that it agrees to accept reimbursement at the rate applicable to a Network Pharmacy as payment in full, it may be possible to receive Benefits on the same basis and at the same cost-share as you would from a Network Pharmacy. The non-Network Pharmacy or its intermediary must, if requested to do so in writing by us or our intermediary, execute and deliver to us or our intermediary, within 30 days of the pharmacy's receipt of our request, the Network provider agreement, which we require of all Network Pharmacies. Any non-Network Pharmacy or its intermediary which fails to timely execute and deliver such agreement will continue to be treated as a non-Network Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

SAMPLE

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

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

Access to benefits for Prescription Drug Products from retail Network Pharmacies is not restricted, unless: (i) the Prescription Drug Product is subject to restricted distribution by the United States Food and Drug Administration (USFDA); or (ii) special handling, provider coordination, or patient education is required for the Prescription Drug Product and cannot be provided by a retail Network Pharmacy.

Prescription Drug Products from a Mail Order Network Pharmacy

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

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

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

PPACA and Preventive Care Medications

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), certain preventive medications are available to you at no cost, both prescription and over-the-counter (OTC). These are called PPACA Zero Cost Share Preventive Care Medications. These preventive medications are covered at no cost to you, without charging a Co-payment, 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 Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy. Refer to your *Schedule of Benefits* for day supply limits.

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

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories. Note that additional classes or categories may be added throughout the benefit year.

- Epinephrine.
- Glucagon.
- Naloxone.
- Albuterol inhalers and nebulized solutions.

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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 or its intermediary. If, however, an Out-of-Network Pharmacy or its intermediary has notified us that it agrees to accept reimbursement at the rate applicable to a Network Pharmacy as payment in full, it may be possible to receive Benefits on the same basis and at the same cost-share as you would from a Network Pharmacy. The Out-of-Network Pharmacy or its intermediary must, if requested to do so in writing by us, execute and deliver to us, within 30 days of the pharmacy's receipt of our request, the participating provider agreement, which we require of all Network Pharmacies. Any Out-of-Network Pharmacy or its intermediary which fails to timely execute and deliver such agreement will continue to be treated as an Out-of-Network Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational Services and medications; medications used for experimental or investigational treatments for specific diseases and/or dosage regimens determined by us to be experimental or investigational.
7. Prescription Drug Products furnished by the local, state or federal government. This exclusion does not apply to Medicaid.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to certain injectable drugs used for contraception.
11. Durable Medical Equipment, for which Benefits are provided in your Policy.
12. Certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy under *Diabetes Services* in *Section 1: Covered Health Care Services*. 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.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to treatment of any underlying cause of infertility.
18. Prescription Drug Products not included on the Prescription Drug List. Please see the *Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)* section in the *Outpatient Prescription Drugs Schedule of Benefits* for information about the exception process.

SAMPLE

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

20. 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 aspirin for the prevention of pre-eclampsia and cardiovascular disease, over-the-counter drugs used for tobacco cessation, or over-the-counter contraceptives.

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

22. 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.

23. Dental products, including but not limited to prescription fluoride topicals. This does not include prescription fluoride supplements for children 0-16.

24. Diagnostic kits and products, including associated services.

25. 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.*

26. Prescription Drug Products when prescribed to treat sexual dysfunction and/or impotency.

SAMPLE

Defined Terms for Outpatient Prescription Drugs

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

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

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

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

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

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

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy may be a:

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

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. This list can be viewed online at [https://www.uhc.com/xvadruglist2024]. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

SAMPLE

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.
- Self-administered injectable drugs.
- Flu shots and their administration.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips;
  - certain insulin pumps;
  - certain continuous glucose monitors;
  - lancets and lancet devices; and
  - glucose meters.

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.

Tier - the applicable prescription drug copayment amount, the prescription drug deductible amount, and the prescription drug coinsurance percentage, if any, are determined by the Tier to which the prescription drug is assigned. Our Prescription Drug List Management Committee ("PDL MC") assigns each prescription drug to a Tier. A Covered Person can determine the Tier status for a prescription drug by accessing his or her prescription benefits via our website at www.myuhc.com/exchange or by calling the telephone number on your identification card. Non-formulary drugs, which are approved for use as Medically Necessary subsequent to clinical review and authorization by the plan, will be subject to the applicable cost share based on the Prescription Drug Product tier placement, or at the second highest tier. For example, if you have a 5-tier plan, then the 4th tier would be considered the second highest tier.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement or pricing agreed to by the pharmacy and any third party. This fee includes any applicable dispensing fee and sales tax.

SAMPLE

Section 11: Pediatric Dental Care Services

How Do You Use This Document?

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

What are Defined Terms?

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either 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 Optimum Choice, Inc. When we use the words "you' and "your" we are referring to people who are Covered Person, as the term in 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. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Benefits for Pediatric Dental Care Services

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

A. Necessary.

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

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

D. Not excluded as described in *Pediatric Dental Exclusions* of this Policy.

Covered Dental Care Services include:

- Dental checkups one time every six-months.

SAMPLE

- Cleaning and fluoride treatments one time every six-months.
- Sealants.
- Space maintainers.
- Extractions.
- Root canal treatment.
- Crowns,
- Dentures.
- X-rays.
- Other Necessary dental services.
- Medically Necessary orthodontic treatment up to the end of the month the Covered Person reaches age 19 years.

The specific services that are covered and details regarding those services are described in the *Pediatric Dental Care Services Schedule of Benefits*.

Benefits

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

Pediatric Dental Exclusions

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

1. Dental Care Services received from an out-of-Network Dental Provider.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section under the heading *Benefits for Pediatric Dental Care Services.*
3. Dental Care Services that are not Necessary.
4. Hospitalization or other Facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental or Investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational 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.

SAMPLE

14. Services related to the temporomandibular joint (*TMJ)*, either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. Except for Occlusal orthotic device for TMJ, which covered only for temporomandibular pain dysfunction or assoc. musculature.
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice, telephone consultations and sales tax.
16. 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.
17. Services rendered by a provider who is a member of your family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered outside of the United States.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. 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.
25. Services that exceed the frequency limitations as identified in this section.

SAMPLE

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.

SAMPLE

Section 12: Pediatric Vision Care Services

How Do You Use This Document?

This section of the Policy provides Benefits for Pediatric 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 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 Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, 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 the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

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

Routine Vision Exam

A routine vision exam of the eyes 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.

Covered eyeglass lenses include choice of lenses, including:

- One pair of standard plastic (CR39) lenses up to 55mm in Single, Bifocal, Trifocal (FT 25-28); and Progressive
- Polycarbonate or photochromic lenses,
- Factory scratch coating,
- UV coating.

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.

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 when your vision is not correctable to 20/40 in either or both eyes using standard eyeglass lenses.
- High ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- When your vision can be corrected three lines of improvement on the visual acuity chart when compared to the best corrected standard eyeglass lenses.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.

SAMPLE

- Post-traumatic disorders.

Low Vision

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

Benefits include:

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

Pediatric Vision Exclusions

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

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

Claims for Low Vision Care Services

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

Reimbursement for Low Vision Care Services

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

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

Send the above information to us:

By mail:

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Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

[248-733-6060]

Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

SAMPLE

Section 13: Consolidated Appropriations Act Summary

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

No Surprises Act

Balance Billing

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

- When Surgical or Ancillary Services are received at Network facilities on a non-Emergency basis from out-of-Network Physicians.
- 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 Network 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 determined as follows:

For covered non-Emergency Health Care Services received at Network Facilities from out-of-Network Physicians when such services are either Surgical or Ancillary Services, the Allowed Amount is based on a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or a commercially reasonable rate, which is defined as the median amount negotiated with Network providers for the same service or similar service provided in a similar geographic area.

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).*

Continuity of Care

If you have an existing provider-patient relationship with a Network Provider who is terminated from the Network for reasons other than cause at your request, for continuation of Covered Health Care Services rendered by the terminated Provider for the time periods shown below. Co-payments, Co-insurance, deductibles, or other cost-sharing components will be the same as you would have paid for a provider currently contracting with us. The terminated Provider will be reimbursed in accordance with our agreement with the Provider existing immediately before the Provider's termination of participation.

Medical conditions and time periods for which treatment by a terminated Network Provider will be covered under the Policy are:

- If a Covered Person has been medically confirmed to be pregnant at the time the Network Provider is terminated, coverage for treatment by the terminated Provider will continue until the postpartum services related to the delivery are completed.

SAMPLE

- If a Covered Person is undergoing a specified course of treatment for a terminal illness or a related condition at the time the Network Provider is terminated, coverage for care directly related to treatment of the terminal illness will continue for the remainder of the Covered Person's life or until coverage under the Policy terminates.
- If a Covered Person has been determined by a medical professional to have a life-threatening condition at the time the Network Provider is terminated, coverage for treatment will continue for up to 180 days for care directly related to the life-threatening condition.
- If a Covered Person is admitted to and receiving treatment in an inpatient facility at the time the Network Provider is terminated, coverage treatment will continue until the Covered Person is discharged from the facility.
- For any other Covered Health Care Services, coverage will continue for 90 days after the date the Provider has been terminated from the Network.

An existing provider-patient relationship means the Network Provider has rendered health care services to the Covered Person or admitted or discharged the Covered Person within the 12 months prior to the provider's termination from the Network.

As used in this provision the term "provider" includes a provider group.

Provider Directories

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

SAMPLE

Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

UnitedHealthcare complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: **UHC_Civil_Rights@uhc.com**

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Phone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at: **https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices**.

SAMPLE

Language Assistance Services 1-877-265-9199, TTY 711

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታውቂያ ቁጥርዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا كنت تتحدث اللغة **العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ।

আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

ATENSION: Yanggen fifino' hao **Chamoru (Chamorro)** guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang i dibåtdi na numiru gi kattå-mu aidentifikasion membro.

請注意：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

SAMPLE

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.
ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole),** gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.
ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।
LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.
PANANGIKASO: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.
ATTENZIONE: Se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.
注意事項：日本語（Japanese）を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。[] にお電話ください。
알림사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.
BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáá łahgo át'éego bee hadadilyaa bee ahił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.
GEB ACHT: Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht, Schprooch Helfe mitaus Koscht un Communications in annere Formats wie groosse Druck iss meeglich. Ruf die koschdelos Nummer uff dei Member Identification Kaart.
PAKAIR: Mah ke ese lokaian **Pohnpei (Pohnpeian)**, sahpis en sawas en lokaia oh mehn kapehse ni soangen mwohmw teikan kin sohte isepe, me duwehte inting lapala, kak kohda ohng kowe. Eker nempe ni sohte isepe me mih pohn noumw doaropwehn tohn pwihn ID.
UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

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 of Protection Provided by Virginia Life, Accident and Sickness Insurance Guaranty Association

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

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits.
- $100,000 in cash surrender and withdrawal values.

Health Insurance

- $500,000 for health benefit plans.
- $300,000 in disability income insurance benefits.
- $300,000 in long-term care insurance benefits.
- $100,000 in other types of accident and sickness insurance benefits.

Annuities

- $250,000 in withdrawal and cash values.

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

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

To learn more about the above protections, please visit the Association's website at https:///www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
c/o DSH Consulting LLC
PO Box 606
534 Main Street
Hampden, MA 01036-9998
571-438-9408

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945

SAMPLE

https://www.scc.virginia.gov/pages/Home

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

SAMPLE