Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits.*
- The Group's *Application.*
- Riders, including the *Outpatient Prescription Drug Rider*, the *Pediatric Dental Services Rider* and the *Pediatric Vision Care Services Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Read your Policy carefully.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends.*

We are delivering the Policy in North Carolina. The Policy is subject to the laws of the state of North Carolina and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, North Carolina law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

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

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations.* Read *Section 8: General Legal Provisions* to understand how this *Certificate* 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 *Certificate* and any summaries provided to you by the Group, this *Certificate* 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 found on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

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

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

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

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* 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.

A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

You may designate a Network Physician who specializes in pediatrics as the Network Primary Care Physician for an Enrolled Dependent child under the age of 18. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

In cases where a referral is required, you may receive an extended or standing referral to an in-plan Specialist. An extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with us in consultation with the Primary Care Physician, the Specialist and you or your designee.

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. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. You are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits.*

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

Disclosure of Payment Obligations

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

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

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 services are 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 the 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 develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our

reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. Payment of claims for Emergency Health Care Services shall be paid the same as a Network Physician or if care is not reasonably available to Co-payment and/or Co-insurance).

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

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

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

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

- Physician's Office Services - Sickness and Injury
- Surgery - Outpatient
- Hospice Services
- Infertility Services
- Private Duty Nursing
- Urgent Care Center Services
- Home Health Care
- Ambulance Services
- Physician's Fees for Surgical and Medical Services
- Obesity Surgery
- Skilled Nursing Facility
- Pregnancy
- Mental Health Care Services
- Substance-Related and Addictive Disorder Services
- Pharmaceutical Products - Outpatient
- Rehabilitation Services - Outpatient Therapy and Manipulative Treatment
- Habilitation Services
- Durable Medical Equipment (DME), Orthotics and Supplies
- Ostomy Supplies
- Routine Foot Care
- Pediatric Vision Care Services
- Pediatric Dental Care Services
- Preventive and Well Baby Care Covered at 100%
- Lab, X-Ray and Diagnostics - Outpatient

- Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient
- Transplantation Services
- Dental Services - Accident Only
- Therapeutic Treatments - Outpatient
- Prosthetic Devices
- Nutritional Counseling
- Sterilization
- Blood Services
- Anesthesia
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Orthotics for Position Plagiocephaly
- Organ Donor Search
- Sexual Dysfunction (related to organic disease only)

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

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

1. Ambulance Services

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

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

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

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

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

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

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

3. Clinical Trials

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

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

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

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

Covered clinical trials must also involve:

- Determination by treating Physician(s);
- Relevant scientific data; and
- Opinions of experts in relevant medical specialties.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs, those related to investigational drugs, 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.
- In the event of a claim that contains charges related to services for which no coverage is available, and those charges have not been or cannot be separated, the claim will be denied.

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 for patient research studies designed to evaluate new treatments, including prescription drugs. It meets any of the following criteria in the bulleted list below.

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

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

Covered clinical trials must be conducted in a setting and by personnel that maintain a high level of expertise

because of their training, experience, and volume of patients.

4. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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

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

- Treatment must be completed within two years of the accident and not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

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

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

6. Diabetes Services

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

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

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

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* Benefits for blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*

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

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

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implants are provided under the applicable medical/surgical Benefit categories in this *Certificate.*
- Custom molded foot orthotics.
- One-time replacement of eyeglass or contact lenses due to a prescription change after cataract surgery.

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

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

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Orthotic devices for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) band and soft helmets. Orthotics, including cranial orthotics, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

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

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

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

8. Emergency Health Care Services - Outpatient

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

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

9. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula and products are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

10. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for embryo transfer.

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

11. Gender Dysphoria

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

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

12. Habilitative Services

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

Habilitative services are limited to:

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

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

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

We may require the following be provided:

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

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

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

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

13. Hearing Aids

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

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

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

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate.* They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

14. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

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

15. Hospice Care

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

- Physical, psychological, social, spiritual and respite care for the terminally ill person.

- Short-term grief counseling for immediate family members while you are receiving hospice care.

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

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

16. Hospital - Inpatient Stay

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

Benefits are available for:

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

17. Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

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

Benefits include:

- Bone mass measurements. Benefits for bone mass measurement will be provided for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. A second bone mass measurement may be provided if at least 23 months has elapsed since the last bone mass measurement was performed.
    - When Medically Necessary, benefits for a follow up bone mass measurement will be provided more frequently than every 23 months. Medically Necessary conditions include but are not limited to:
    - Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.
    - Central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual with proven low bone mass, provided the measurement is performed 12 to 18 months from the start date of the additional regiment.
- Cervical cancer screening for the early detection of cervical cancer in accordance with the most recent published *American Cancer Society* guidelines or guidelines adopted by the *North Carolina Advisory Committee on Cancer Coordination* and control including:
    - Pap smears
    - Liquid-based cytology
    - Human papilloma virus (HPV) detection method for woman with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the *United States Food and Drug Administration.*
- Mammography screening. Benefits for screening mammography include:
    - One or more mammograms a year, as recommended by a Physician for any woman who is at risk for breast cancer;

- One baseline mammogram age 35 - 39 years of age.
- A mammogram every other year for age 40 - 49 years of age.
- A mammogram every year for age 50 or older.

- Newborn hearing screening ordered by the attending Physician.
- Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a Physician.

Preventive screenings included in the comprehensive guidelines supported by the *Health Resources and Services Administration* are described under *Preventive Care Services.*

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

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

18. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

19. Mental Health Care and Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Biofeedback.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
  - Care for an individual diagnosed with Autism Spectrum Disorder, or equipment related to that care, ordered by a licensed Physician or a licensed psychologist who determines the care to be Medically Necessary.

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

20. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

21. Pharmaceutical Products - Outpatient

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

Benefits are provided for Pharmaceutical Products which due to their trait (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 *Certificate.* Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

You cannot refill a prescription until 75 percent of the applicable supply limit for the medication has been used, except under certain circumstances during a state of emergency or disaster.

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

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

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 or the telephone number on your ID card.

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

22. 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.

23. Physician's Office Services - Sickness and Injury

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

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

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include certain services related to the diagnosis, treatment and correction of any underlying causes of Sexual Dysfunction for all Covered Persons. Benefits may vary depending on where services are received.

Benefits include allergy injections and allergy testing.

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.*

24. Pregnancy - Maternity Services

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

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.

Please note: Prior authorization is not required for the minimum Hospital Inpatient Stay following childbirth.

Post Delivery Follow-up Care

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

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

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

25. Preimplantation Genetic Testing (PGT) and Related Services

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

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

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

26. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.* Benefits for colorectal cancer screenings that do not have in effect a rating of either "B" or "A" described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration,* including tubal ligation.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:
  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.

Benefits for screenings that do not meet the criteria above are described under *Lab, X-Ray and Diagnostic - Outpatient.*

27. Prosthetic Devices

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

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

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

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

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

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

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

28. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. A reconstructive procedure for treatment of a Congenital Anomaly of a newborn child, foster and adoptive children is not considered a Cosmetic Procedure.

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

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

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

29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Chiropractic Care)

Short-term outpatient rehabilitation services limited to:

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

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

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

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

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain injury or stroke.

30. 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.

Benefits include colorectal cancer screenings. Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force are described under Preventive Care Services.*

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

Benefits include:

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

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

31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

32. Surgery - Outpatient

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

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

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

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

Benefits include:

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

33. Therapeutic Treatments - Outpatient

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

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.
- Transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream.
- Storing a Covered Person's own blood only when stored and used for a previously scheduled procedure.

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 when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

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

34. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

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

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

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

35. Urgent Care Center Services

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

36. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

37. 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 or the telephone number on your ID card.

Benefits are available for urgent, on-demand health care delivered through live audio with video conferencing 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).

Additional Benefits Required By North Carolina Law

38. Dental - Anesthesia and Hospital or Facility Charges

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

Persons eligible for this benefit include:

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

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

39. Infertility Services

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

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

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

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

For the purpose of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

40. 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:

(1) Require a prescription;

(2) Are custom-fit for the Covered Person; and

(3) Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

41. Ovarian Cancer Surveillance

- Benefits for ovarian cancer surveillance tests:
- Ovarian cancer surveillance tests for women age 25 and older who are at risk for ovarian cancer. For purposes of this Benefit, the following definitions apply:
- "Surveillance Tests" means annual screening using:
  - Rectovaginal ultrasound; and
  - Transvaginal ultrasound.
- "At Risk for Ovarian Cancer" means:
  - Having a family history;
  - With at least one first degree relative with ovarian cancer; and
  - A second relative either first degree or second degree, with breast, ovarian or nonpolyposis colorectal cancer; or
  - Testing positive for a hereditary ovarian cancer syndrome.

42. Private Duty Nursing

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

43. Temporomandibular Joint (TMJ) Services

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

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

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

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

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

Benefits for surgical services include:

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

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

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or other similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services.*

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under *Dental - Anesthesia and Hospital or Facility Charges* in *Section 1: Covered Health Care Services.*

   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, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

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

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 also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* or *Temporomandibular Joint (TMJ) Services* 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). This exclusion does not apply to orthodontia or prosthodontics for treatment of cleft lip/cleft palate.
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, except as part of a Congenital Anomaly. This exclusion does not apply to Congenital Anomalies for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics except for those used to treat diabetes, and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.* This exclusion does not apply to Benefits as described under *Diabetes Services* 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.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
5. Oral appliances for snoring.

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

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to Benefits as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration. This exclusion does not apply to Benefits as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
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 or to contraceptive drugs for which Benefits are provided as required by state law.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy except for a Dependent child who requires growth hormone therapy to treat a Congenital Anomaly.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition except as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to coverage of any drug solely on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the *FDA.* The drug, however, must be approved by the *FDA* and must have been proven effective and accepted for treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- *The National Comprehensive Cancer Network Drugs & Biologics Compendium;*
- *DRUGDEX System by Micromedex;*
- *The Elsevier Gold Standard's Clinical Pharmacology;* or
- Any other authoritative compendia as recognized periodically by the *United States Secretary of Health and Human Services.*

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

F. Foot Care

1. Nail trimming, nail cutting, or nail debridement. Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic , or peripheral vascular disease. This exclusion does not apply to Benefits as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
2. Treatment of flat fee
3. Treatment of subluxatio of the foot.
4. Shoes. This exclusion does not apply to Benefits as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
5. Shoe orthotics. This exclusion does not apply to Benefits as described under *Diabetes Services* or *Durable Medical Equipment (DME), Orthotics, and Supplies* in *Section 1: Covered Health Care Services.*
6. Shoe inserts.
7. Arch supports.

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
    - Abdominoplasty.
    - Blepharoplasty.
    - Breast enlargement, including augmentation mammoplasty and breast implants.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.

- Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies except this exclusion does not apply to diabetic supplies. Please note that if you have an *Outpatient Prescription Drug Rider* that provides coverage for diabetic medications and supplies, Benefits are also available under the Rider and this *Certificate.*

Examples of supplies that are excluded include:

- Compression stockings. This does not apply to diabetic supplies.
- Ace bandages.
- Gauze and dressings.

This exclusion does not apply to:

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

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

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

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations,* the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.* These exclusions do not apply to the following illnesses: Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. 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.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria,* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. Nutritional counseling will be covered as a preventive service as part of the obesity screening for both adults and children. Intensive behavioral dietary counseling for adults is also considered preventive for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services.*
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

K. Personal Care, Comfort or Convenience

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms.* Examples include:
   - 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, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. 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.
8. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
10. Non-surgical treatment of obesity.

11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
13. Helicobacter pylori *(H. pylori)* serologic testing.
14. Intracellular micronutrient testing.
15. Charges for the collection or obtainment of blood or blood products from a blood donor, including the Covered Person in the case of autologous blood donation.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
    - Has not been involved in your medical care prior to ordering the service, or
    - Is not involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

O. Reproduction

1. The following infertility treatment-related services:
    - In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), pronuclear stage tubal transfer (PROST), tubal embryo transfer (TET), and zygote intrafallopian transfer (ZIFT).
    - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
    - Donor services.

    This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*
2. The following services related to a Gestational Carrier or Surrogate:
    - All costs related to reproductive techniques including:
        - Assisted reproductive technology.
        - Artificial insemination.
        - Intrauterine insemination.
        - Obtaining and transferring embryo(s).
        - Preimplantation Genetic Testing (PGT) and related services.
    - Health care services including:
        - Inpatient or outpatient prenatal care and/or preventive care.

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

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

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

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. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

P. Services Provided under another Plan

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

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

R. Travel

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

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services.*
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to Benefits provided through any *Pediatric Vision Care Services Rider* issued with this *Certific ate of Coverage.*
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to Benefits provided through any *Pediatric Vision Care Services Rider* issued with this *Certificate of Coverage.*
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. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:

- Required only for school, sports or camp, travel, career or employment, insurance, marriage or services, incidental to or adoption, which are required prior to placement for adoption.
- Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
- Required to get or maintain a license of any type.

3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply to continuity of care as described under the *Continuity of Care* provision in *Section 4: When Coverage Ends.*
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation, except for Emergency Health Care Services and services outside the provider Network when no care is available from a Network provider.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy, except when the autopsy is done at your request.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
12. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

Replacement of Prior Group Insurance

When the medical insurance under this Policy replaces medical insurance from another insurer, each person who is eligible for coverage in accordance with this Policy, regardless of any other provisions of this Policy relating to active employment or Hospital Inpatient Stay or Pregnancy, shall be covered under this Policy.

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 the Policy.

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

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

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms.*

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber'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 9: Defined Terms.*

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

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement of a child in a home for foster care or adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order regardless of the lapse in time from court or administrative order.

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

If an additional monthly Premium will be required to enroll a new spouse or a new Dependent child, you must submit an enrollment application and change form through the Group within 31 days of acquiring the new Dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive home/foster home.

If no additional monthly Premium will be required when you add a Dependent child to your plan, you should complete a status change form so that we may send an identification card to facilitate the child's access to Covered Health Care Services. A newborn child will be covered from the moment of birth. A foster care child or adopted child will be covered from the date of placement in the home.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement of a child in a home for foster care or adoption.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility including:
    - Legal separation;
    - Divorce;
    - Death of an employee;
    - Cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent child);
    - Termination of employment;
    - Reduction in the number of hours of employment.
  - The employer stopped paying the contribution. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and must pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

Please note: If additional monthly Premiums are not required, a 31-day notice is not required in the event of a newborn, adopted or foster child.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted_above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy. This includes terminating coverage on the date we specify, after at least 90 days prior written notice to the Group, Subscriber and beneficiary that this Policy shall be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market. Except for the termination reasons stated in the Policy, all group health benefit plans are guaranteed renewable at the option of the employer.

Please note that coverage will end on the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, Subscriber and beneficiary that this Policy shall be terminated because we will no longer issue any employer health benefit plan within the applicable market.

Upon termination of a group health insurance contract by us, we shall notify every Subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided.

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

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

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

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 the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application,* and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

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

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After two years from the date of issue or reinstatement of this Policy, no misstatement except fraudulent misstatement made by the applicant in the application for such Policy shall be used to void the Policy or deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two-year period.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber 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 the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

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

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

Continuity of Care

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

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

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

- In general, you will have up to 90 days from the date of notice that such provider is no longer a Network provider, to continue treatment with your provider before benefits will end.
- For surgery, organ transplant, or inpatient care that was schedule before you received notice that such provider is no longer a Network provider, or if you were on an established waiting list, the transitional period shall extend through the date of discharge. In addition, coverage with that provider shall include post discharge follow-up care related to the surgery, transplantation, or other inpatient care happening within 90 days after the date of discharge.
- For Pregnancy, if you have entered the second trimester of pregnancy on the date of notice that such provider is no longer a Network provider, you will have benefits with that provider through treatment of the pregnancy, which shall include 60 days of postpartum care.

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

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliati on Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Group will provide you with written notification of the right to continuation coverage within 60 days of when coverage ends under the Policy. You must elect continuation coverage within 31 days of receiving this notification. You should get an election form from the Group or the employer and once election is made, forward all monthly Premiums to the Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 18 months from the date continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date the Covered Person becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.
- The date the Policy ends.

Conversion

If your coverage ends for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

You should submit a request for payment of Benefits within 180 days after the date of service. If you don't provide this information to us within one year from the end of the 180-day period, 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.

NOTICE OF CLAIM: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to us, or to any authorized agent of ours, with information sufficient to identify the insured, shall be deemed notice to us.

Indemnities payable under the policy for loss will be paid immediately upon receipt of due written proof of such loss.

CLAIM FORMS: Upon receipt of a notice of claim, we will provide proof of loss forms to you. If these forms are not provided within 15 days after giving us notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

PROOFS OF LOSS: Written proof of loss must be furnished to us in the case of a claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 180 days after the termination of the period for which we are liable and in case of a claim for any other loss within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under the Policy for any loss other than loss for which the Policy provides any period payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

Required Information

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

- The Subscriber'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

PO Box 650629

Dallas, TX 75265-0629

Payment of Benefits

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

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

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

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

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

Section 6: Grievance and Appeal Procedure

Health Insurance Smart NC is available to provide information, advice and assistance to consumers. Services provided by *Health Insurance Smart NC* are available through the *North Carolina Department of Insurance.* To reach this Program, contact *Heath Insurance Smart NC, North Carolina Department of Insurance* , 1201 Mail Service Center, Raleigh, NC 27699-1201, by telephone toll free at (855) 408-1212 or at https://www.ncdoi.gov/consumers/health-insurance.

This section provides you with information to help you with the following:

- Utilization review process.
- Non-certification appeal.
- Your grievance procedures.

In this section, you will find information regarding UnitedHealthcare's utilization review process, together with a description of the non-certification appeal and grievance procedures, and your grievance procedures. The appeal and grievance procedures described below are voluntary, and ensure that you have the opportunity for appropriate resolution of any grievance or any non-certification of requested health services.

If you have a concern or question regarding health care services or benefits provided under the Policy, you should call the telephone number shown on your identification card. An authorized representative will attempt to resolve your concern through informal discussions.

The *North Carolina Department of Insurance* (NCDOI) is available to assist you with insurance related problems and questions. Inquiries may be directed in writing to NCDOI at 9001 Mail Service Center, Raleigh, NC 27699-1201, in person at Albemarle Building, 325 N. Salisbury St, Raleigh, NC, or by telephone (Toll-free in NC) (855) 408-1212.

Utilization Review

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

Utilization Review Program Operation

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

In issuing utilization review decisions, UnitedHealthcare will obtain all information required to make the decision, including pertinent clinical information; ensure that utilization reviewers apply clinical review criteria consistently; and, issue timely decisions in accordance with applicable law. UnitedHealthcare will limit requests for information to only that information that is necessary to certify the service in question, and will provide notification of utilization review decisions consistent with applicable law. UnitedHealthcare may not certify an admission or service if you or your Physician are unable to provide, or fail to release, necessary information in a timely manner. Whenever prior certification is required in order to receive requested services, utilization review staff may be contacted by you and/or your Physician at the phone number listed on your ID Card.

Urgent Care Review

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

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

- Within 24 hours of receipt of claim, UnitedHealthcare must make the request for additional information.

- You will have 48 hours from receipt of UnitedHealthcare's request to supply the information.

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

Prospective (Pre-service) and Concurrent Reviews

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

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

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

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

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

Retrospective (Post -Service) Reviews

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

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

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

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

Appeal and Grievance Procedures

You have certain appeal and grievance rights under the laws of North Carolina and the *United States Department of Labor.* As described below, you have the right to appeal an adverse benefit determination. This includes the right to appeal noncertification decisions as well as the right to appeal on-clinical (benefit) determinations.

In the case of noncertification appeals:

- There is one level of appeal available through UnitedHealthcare.
- You may also be entitled to request an independent external review through the NCDOI as explained below.

In case of a non-clinical (benefit) appeal:

- There are two levels if internal review available through UnitedHealthcare.
- Independent external review through the NCDOI is not available for non-clinical appeals.

Noncertification (Clinical) Appeals

You, or another person or Physician authorized to act on your behalf, have 180 days from the date of the noncertification to appeal noncertification determinations. You should make the request to UnitedHealthcare at UnitedHealthcare - Appeals, P.O. Box 30573, Salt Lake City, UT, 84130-0573

FAX: 801-938-2100. The NCDOI is available to assist you with your request. Contact *Health Insurance Smart NC, North Carolina Department of Insurance* in writing at 1201 Mail Service Center, Raleigh, NC 27699-1201 or by telephone at (Toll-free in NC) 855-408-1212 or at https://www.ncdoi.gov/consumers/health-insurance. The appeal will be evaluated by a North Carolina licensed medical doctor who was not involved in the initial noncertification decision. As described below, noncertification appeals may be expedited under certain circumstances.

Standard Noncertification Appeals

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

Expedited Noncertification Appeal

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

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

External Review

North Carolina law provides for review of non-certification decisions by an external, independent review organization (IRO). The *North Carolina Department of Insurance* (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. UnitedHealthcare will notify you in writing of your right to request an external review each time you:

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

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

- That your request is about a medical necessity determination that resulted in a non-certification decision;
- That you had coverage with UnitedHealthcare in effect when the non-certification decision was issued;
- That the service for which the non-certification was issued appears to be a Covered Health Care Service under your Policy; and
- That you have exhausted UnitedHealthcare' internal review process as described below.

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

Standard External Review

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

- Completed the UnitedHealthcare appeal process and received a written determination on the appeal from UnitedHealthcare; or
- Filed an appeal and, except to the extent that you have requested or agreed to a delay, have not received UnitedHealthcare' written decision on appeal within 60 days of the of the date you can demonstrate that a grievance was filed with UnitedHealthcare, or
- Received notification that UnitedHealthcare has agreed to waive the requirement to exhaust the internal appeal process.

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

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

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

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

If you choose to provide any additional information to the IRO, you must also provide the same information to UnitedHealthcare at the same time using the same means of communication (e.g. you must fax the information to UnitedHealthcare if you faxed it to the IRO). When faxing information to UnitedHealthcare, send it to 877-836-5247. If you choose to mail your information, send it to:

UnitedHealthcare - Appeals
P.O. Box 30573
Salt Lake City, UT, 84130-0573

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

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

Expedited External Review

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

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

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

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

NCDOI will notify UnitedHealthcare, you and your provider within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may:

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

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

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

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

For further information about external review or to request an external review, contact the NCDOI at:

By mail at: *North Carolina Department of Insurance, Health Insurance Smart NC,* 1201 Mail Center, Raleigh, NC 27699-1201, Toll Free Telephone: (855) 408-1212, (Fax) (919) 807-6865.

In Person: For the physical address for *Health Insurance Smart NC,* please visit the website: https://www.ncdoi.gov/consumers/health-insurance

Toll Free Telephone: (855) 408-1212

Website: https://www.ncdoi.gov/consumers/health-insurance/ health-claim-denied/request-external-review

***Health Insurance Smart NC* is available to provide consumer counseling on utilization review and internal appeals and grievance issues.**

Non-Clinical Appeals (Benefit Grievances)

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

First-Level Grievance Review

You, or another person authorized to act on your behalf, may voluntarily request a review of any decision, policy, or action of UnitedHealthcare that affects you. You have 180 days from the date of receipt of any adverse benefit determination to request a review of this determination. You may submit written material for consideration. Within 3 business days after receiving your grievance request, you will be provided the name, address, and telephone number of one of UnitedHealthcare's authorized representatives, with instructions on how to submit additional written material. A written decision, in clear terms, will be issued to you and, if applicable, to your provider as follows:

- For a Prospective (pre-service) review: within 15 days after receiving the grievance.
- For a Retrospective (post-service) review: within 30 days after receiving the grievance.

If the grievance is concerning the quality of health care service you have received from your Physician, UnitedHealthcare will notify you within 10 business days that the grievance has been referred to the *quality improvement department/committee* for review and consideration. **State law does not allow second level grievance review for grievances concerning quality of care.**

Second-Level Grievance Review

If you are dissatisfied with the first-level grievance decision, you may make a request for second-level non-clinical grievance review. You should make the request to UnitedHealthcare - Appeals, P.O. Box 30573, Salt Lake City, UT, 84130-0573, FAX: 80[illegible]938[illegible]100. The NCDOI is available to assist the Member with the Member's request. Contact *Heath Insurance Smart NC, North Carolina Department of Insurance*, 1201 Mail Service Center, Raleigh, NC 27699-1201, by telephone toll free at (85[illegible] 40[illegible]-121[illegible] or at http://www.ncdoi.gov/consumers/health-insurance. Upon receiving a request for a second-level non-clinical grievance review, you will be informed of the following within 10 business days:

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

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

Second-Level Grievance Review Procedures

A second-level grievance hearing will be scheduled, held and a decision issued according the following timeframes:

- For a Prospective (pre-service) review: within 15 days after receiving the grievance.
- For a Retrospective (post-service) review: within 30 days after receiving the grievance.

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

UnitedHealthcare will issue a written decision, in clear terms, to you and, if applicable, to your authorized representative. Independent external review through the NCDOI is not available for non-clinical reviews.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

A. **Plan.** A Plan is any of the following that provides benefits or services for, or because of, medical, pharmacy or dental care or treatment, including prepayment, group practice or individual practice coverage. 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 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: 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; blanket; franchise; individual; automobile and homeowner coverages; 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. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

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

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

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

D. **Allowable Expense.** A necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. Total benefits paid must be equal to 100 percent of necessary medical expenses covered by both plans.

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's 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 *Certificate.*
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

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

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

Coverage Determination

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

What Is Our Relationship with Providers and Groups?

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

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions. While we may arrange for goods, services and/or third party provider discounts, the third party services are liable to you for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor are we liable for the failure of the provision of the same. Further, we are not liable to you for the negligent provision of such goods and/or services by third party service providers.

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 final authority to do all of the following:

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

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

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

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

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the 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 the 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. 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 Subscriber'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 the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

When Do We Receive Refunds of Overpayments?

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

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by

reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement prior to the expiration of 60 days after written proof of loss has been furnished. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. In the interest of expediting the resolution of any complaints you might have we encourage you to follow the grievance process outlined in *Section 6: Grievance and Appeal Procedure* before you bring any legal proceeding or action against us.

What Is the Entire Policy?

The Policy, this *Certificate,* the *Schedule of Benefits,* the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Certification of Coverage Form

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

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

- At the time you cease to be covered under the plan (or otherwise become covered under *COBRA* continuation provision).
- In the case of your becoming covered under a *COBRA* continuation provision, at the time the individual ceases to be covered under the *COBRA* continuation provision.
- Upon request on your behalf when the request is made not later than 24 months after the date coverage ends, as described in the first and second bullet points above, whichever is later.

The Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on the eligibility and termination data that the Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

Care Cash Program

Care Cash is a program that provides access to a prefunded debit card that may be used for certain eligible expenses as defined by the program to help with cost share obligations.

For example, an eligible expense may include certain medical expenses when you choose to seek care in a more cost-effective setting.

You can find more information about the Care Cash program by contacting us at www.myuhc.com.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health Savings Account (HSA)* or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 or more steps per day	You can earn rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Health-Related Actions and/or Activities	One or more actions and/or activities defined by us and aimed at the following: • Health education; • Improving health; or • Maintaining health	

You may access your actions and/or activity tracking and rewards on www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to a *Health Savings Account (HSA)* or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.

Section 9: Defined Terms

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

Allowed Amounts - for Covered Health Care Services, incurred while 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 in accordance with one or more of the following methodologies:

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

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

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

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

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

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

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; 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.

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

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

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.

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

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

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

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function. Cosmetic procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child.

Covered Clinical Trials - phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

- Involve the treatment of life threatening medical conditions;
- Are medically indicated and preferable for the patient compared to available non-investigational treatment alternatives; and
- Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered Clinical Trials must also meet the following requirements:
    - Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
    - Must be trials approved by centers or cooperative groups that are funded by the *National Institute of Health, the Food and Drug Administration, the Center for Disease Control, the agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs.* The health benefit plan may also cover clinical trials sponsored by other entities.
    - Must be conducted in a setting by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Covered Clinical Trials does not include costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those that are not investigational drugs and devices, those that are not provided for the direct clinical management of the patient, and those that are received after the clinical trial has been discontinued.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which are determined 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 *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described

in *Section 3: When Coverage Begins,* the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child in the care of the Subscriber or the Subscriber's spouse for adoption or foster care from the moment of placement.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.* Coverage will take effect the date requested regardless of the lapse in time from when the court order was given.

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 month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*
- A Dependent includes an unmarried dependent child of any age who
  - is or continues to be incapable of self-sustaining employment by reason of mental disability or physical handicap:
  - Proof of such incapacity and dependency shall be furnished to the insurer, hospital service plan corporation, or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation, but not more frequently than annually after the child's attainment of the limiting age.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

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

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

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

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

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

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

Designated Provider - a provider and/or facility that:

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

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

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

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

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

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

Eligible Employee - an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

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

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

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

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C.1395dd(e)(3)).*
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

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

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

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

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

e) Any other conditions as specified by the Secretary.

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

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

Employee - a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. When determining employee eligibility for a large employer, as defined in *N.C.G.S. 58-68-25(10),* an individual proprietor, owner, or operator shall be defined as an Employee for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

Enrollment Date - the date of enrollment of the Subscriber in the coverage or, if earlier, the first day of the waiting period for the enrollment.

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

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

1. Not approved by the U.S. *Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
   - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

- You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

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

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

Foster Child - a minor:

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

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

Genetic Testing - examination 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.

Grandfathered Health Plan - a health benefit plan providing coverage considered grandfathered health coverage described in *45 C.F.R. §147.140(a).*

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

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

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

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

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

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

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.
- Hospital also includes a North Carolina State tax supported institution, whether or not the institution has an operating room and related equipment for surgery.

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

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

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary Services or Supplies - those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, Injury or disease.

- Except as allowed under *N.C.G.S. 58-3-255,* not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, Injury, disease or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the Covered Person, the Covered Person's family or the provider.

For Medically Necessary Services, nothing in this definition shall preclude us from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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 as Mental Illness is defined in *Section 9: Defined Terms* in the *Certificate of Coverage.*

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

Mental Illness - has the same meaning as in *N.C.G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders,* DSM-5, or subsequent editions published by the *American Psychiatric Association,* except those mental disorders coded in the DSM-5 or subsequent editions as Autism Spectrum Disorder (299.00), as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as Sexual Dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

Minimum Essential Coverage - type of coverage an individual needs to have to meet the individual responsibility requirement under the *Affordable Care Act.* This includes individual market policies, job-based coverage, *Medicare, Medicaid, CHIP, TRICARE* and certain other coverage.

MNRP - MNRP is the acronym for Maximum Non-Network Reimbursement Program. The MNRP payment option is the percentage of the Medicare payment option.

Network - a group of providers that have a participating agreement in effect (either directly or indirectly) with us or with our affiliates.

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

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

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

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria,* 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.

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

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-Network Facility Based Physician - any Physician who is an Out-of-Network Provider that provides Covered Health Care Services in a facility.

Out-of-Network Provider - a provider who does not have a participating agreement in effect (either directly or indirectly) with us or with our affiliates.

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

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

Per Occurrence Deductible - the portion of the Allowed Amount or the Recognized Amount when applicable, (stated as a set dollar amount) that you must pay for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount or the Recognized Amount when applicable.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

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 issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- Group *Application.*
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

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

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act.* For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

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

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

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

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

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

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

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.

- Counseling.
- Referral and orientation to specialized community resources.

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

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

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

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

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

Shared Savings Program - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by us.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

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.

Small Employer - an individual actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within North Carolina, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by North Carolina, shall be considered one employer. Subsequent to issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provision of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this Act, the term small employer includes self-employed individual.

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

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

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of chemical dependency which means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

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

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.

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

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

Urgent Care Center - 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.

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.

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addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

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

Please note:

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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.

UnitedHealthcare Non-Differential PPO

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Benefits are payable for Covered Health Care Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or an Out-of-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Care Services. If you receive Covered Health Care Services from a Network provider, your Co-insurance level will remain the same. However, the portion that you owe may be less than if you received services from an out-of-Network provider because the Allowed Amount may be a lesser amount.

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

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

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

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

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

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a UnitedHealthcare Policy.

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 by the Group, this *Schedule of Benefits* will control.

The self-only limitations on cost-sharing applies to each individual regardless of whether the individual enrolled in self-only or other than self-only plan.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

When you choose to receive certain Covered Health Care Services, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits.* You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a Policy year basis.

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

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

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. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts
• Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, when applicable. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	

Co-payment

Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.

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

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

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

Co-insurance

Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.

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

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*	*Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
2. Cellular and Gene Therapy			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	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.*		
3. Clinical Trials			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
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.*		

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*		
5. Dental Services - Accident Only			
	20%	Yes	Yes
6. Diabetes Services			
Prior Authorization Requirement You must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement You must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
	20%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Benefits for Emergency Health Care Services are provided to the extent necessary to screen and to stabilize the Covered Person. 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.*	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
9. Enteral Nutrition			
	20%	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement You must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	20%	Yes	Yes
11. Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

You must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

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.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider.*		
12. Habilitative Services			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased by 50% of the Allowed Amount.			
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies are limited per year as follows: • 23 visits of physical therapy. • 23 visits of occupational therapy. • 20 Manipulative Treatments. • 30 visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive therapy.	*Outpatient* 20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
13. Hearing Aids			
Limited to one hearing aid per ear every 36 months for Covered Persons. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20%	Yes	Yes
14. Home Health Care			
Prior Authorization Requirement You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	20%	Yes	Yes
15. Hospice Care			
Prior Authorization Requirement You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Hospital - Inpatient Stay			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	20%	Yes	Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	20%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
18. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	20%	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Inpatient 20%	Yes	Yes
	Outpatient 20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	20% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
20. Ostomy Supplies			
	20%	Yes	Yes
21. Pharmaceutical Products - Outpatient			
	20%	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician at certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*	20%	Yes	Yes
23. Physician's Office Services - Sickness and Injury			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
24. Pregnancy - Maternity Services			
Prior Authorization Requirement You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	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.		
25. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement You must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility.* This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider.*	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
26. Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
Breast pumps	None	Yes	No
27. Prosthetic Devices			

Prior Authorization Requirement

You must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

	20%	Yes	Yes
28. Reconstructive Procedures			

Prior Authorization Requirement

You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	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.*		
29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Chiropractic Care)			
Limited per year as follows: • 23 visits of physical therapy. • 23 visits of occupational therapy. • 20 Manipulative Treatments. • 30 visits of speech therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	20%	Yes	Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to 60 days per ye	20%	Yes	Yes
32. Surgery - Outpatient			
Prior Authorization Requirement For cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
33. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement You must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	20%	Yes	Yes
34. Transplantation Services			
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	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.*		
35. Urgent Care Center Services			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
36. Urinary Catheters			
	20%	Yes	Yes
37. Virtual Care Services			
Please note: coverage under this item is not provided as part of essential health benefits or as a state mandate. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	Yes	Yes
Additional Benefits Required By North Carolina Law			
38. Dental - Anesthesia and Hospital or Facility Charge			
	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.*		
39. Infertility Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	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.*		
40. 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.*		
41. Obesity - Weight Loss Surgery (Bariatric Surgery)			
Prior Authorization Requirement For Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
	20%	Yes	Yes

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 *Certificate,* Recognized Amounts. The Allowed Amounts provision near the end of this Schedule of Benefits will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
42. Ovarian Cancer Surveillance			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
43. Private Duty Nursing			
	20%	Yes	Yes
44. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	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.*		

Allowed Amounts

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

For Covered Health Care Services from out-of-Network providers, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.

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

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

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

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

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

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

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

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

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

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

Except as described above, Allowed Amounts are determined based on either of 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, Allowed Amounts are determined, based on:
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Care Services other than Pharmaceutical Products, Allowed Amounts are determined based on available data resources of competitive fees in that geographic area.
    - When Covered Health Care Services are Pharmaceutical Products, Allowed Amounts are the average wholesale price of such Pharmaceutical Products as set forth in the *Red Book* drug pricing resource. The Pharmaceutical Product pricing information is updated annually.
    - When *Red Book* does not have a price for the product, an alternative pricing source such as *RJ Health* or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered Pharmaceutical Product will be used.
  - When a rate is not available for the service, the Allowed Amount is based on 20% of the billed charge.

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

Provider Network

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

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

A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

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

Designated Providers

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

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate.*

UnitedHealthcare Insurance Company

Jessica Paik, Preside

Introduction

Coverage Policies and Guidelines

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

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

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

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

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

You cannot refill a prescription until 75 percent of the applicable supply limit for the medication has been used, except under certain circumstances during a state of emergency or disaster.

Identification Card (ID Card) - Network Pharmacy

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

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

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

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

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 opt-out of the Designated Pharmacy program by contacting us at www.myuhc.com or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product

at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Pharmacy Co-payment and/or Co-insurance.

Smart Fill Program - Split Fill

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

Smart Fill Program - 90-Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90-day supply of certain Specialty Prescription Drug Products if you are stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program.* You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

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

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

Coupons, Incentives and Other Communications

From time to time we may offer or provide certain persons who are Covered Persons with a variety of messages, including information about Prescription Drug Products. In addition, we may arrange for third parties (i.e., Pharmaceutical manufacturers) to provide to those persons who are Covered Persons, with mailing that may contain coupons or offers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at a no charge. While we have arranged for the provision of these discount coupons or offers, these third parties may pay for and/or provide content for the mailings. We are not responsible for the provision of such goods and/or services nor liable for the failure of the provision of the same. Further, we are not liable to the Covered Persons for the negligent provision of such goods and/or services by third parties. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc. com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

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

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

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

Note: Co-insurance for a Prescription Drug Product at Network Pharmacy is a percentage of the Prescription Drug Charge. For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Co-payment and/or Co-insurance, or
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product,
- The Prescription Drug Charge for that Prescription Drug Product.

Co-insurance for a Prescription Drug Product at an Out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, and you choose to obtain your Specialty Prescription Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance for that Specialty Prescription Drug Product.

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

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

Prescription Drugs from a Retail Network Pharmacy

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

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

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

Prescription Drugs from a Retail Out-of-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

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

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

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

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

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

Section 2: Exclusions

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

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.

   This exclusion does not apply to any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal *Food and Drug Administration (FDA).* The drug, however, must be approved by the *FDA* and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

   - *The National Comprehensive Cancer Network Drugs & Biologics Compendium;*
   - *DRUGDEX System by Micromedex;*
   - *The Elsevier Gold Standard's Clinical Pharmacology;* or
   - Any other authoritative compendia as recognized periodically by the *United States Secretary of Health and Human Services.*

   Drugs that are the subject of an ongoing clinical trial and meet the definition of a Phase I, II, or III trial included under Covered Clinical Trials in the *Certificate of Coverage* under *Section 9: Defined Terms.*
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. 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.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate.* This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate.* Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed. Does not apply when a state of emergency or disaster is declared by a state or federal official that includes a directive regarding prescription refills.
16. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.
17. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
18. 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 six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our [illegible] Management Committee.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition), except for an Enrollee Dependent child who requires growth hormone therapy for a congenital anomaly.
21. Any oral non-sedating antihistamine or antihistamine-decongestant combination.
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

29. Dental products, including but not limited to prescription fluoride topicals. For further detail, please see the *Preventive Services* section of the *Pediatric Dental Services Rider.*

30. A Prescription Drug Product with either:

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

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

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products, including associated services.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

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

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

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

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

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible, or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

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

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

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

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered

biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits,* in addition to any applicable Ancillary Charge.

Urgent Requests

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

External Review

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

Expedited External Review

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

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

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

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

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a Biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

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

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

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

Do Prior Authorization Requirements Apply?

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

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

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

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.co m or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

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

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

What Do You Pay?

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

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate:*

- Ancillary Charges.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.

- 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.

Payment Information

Payment Term And Description	Amounts
Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	$5,000 per Covered Person.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. Example of Co-insurance under a Network Pharmacy: Retail drug cost - $52.00 Contracted rate - $40.00 Your Co-insurance is 20%. You would pay 20% of $40.00, which is $8.00. Your Co-insurance amount is $8.00. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription	

Payment Term And Description	Amounts
Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. We designate certain Network Pharmacies to be Preferred Specialty Network Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at www.myuhc.com or by the telephone number on your ID card. If you choose to obtain your Specialty Prescription Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Preferred Specialty Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: $0 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $125 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: $500 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. ***Non-Preferred Specialty Network Pharmacy*** You will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	For a Tier 2 Specialty Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $125 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: $500 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $300 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $300 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply and a 30-day supply with three refills.	For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $40 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $300 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $20 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $80 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $250 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $600 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $25 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
	For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $100 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $312.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $750 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill.