UnitedHealthcare Select Plus

Gold Level Plan

UnitedHealthcare Insurance Company

Medical Schedule of Benefits

ANNUAL DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Covered Persons will have to meet a higher Annual Deductible and Out-of-Pocket Maximum when a non-Network provider is chosen to provide Covered Health Services.

IMPORTANT NOTICE - LIMITATIONS ON PROVIDER NETWORK AVAILABILITY

Benefits are restricted to Covered Health Services provided by Network providers for the following: congenital heart disease surgeries; obesity surgery; preventive care services; and transplantation services.

Enrolled Dependents who do not reside with the Subscriber and live outside the Service Area must see a Network provider in order to obtain Benefits for the Covered Health Services listed above.

DIRECTORY OF NETWORK PROVIDERS

The current directory of Network providers is available online at www.myuhc.com. You may obtain a paper copy of the network provider directory at no cost by contacting Customer Care at the telephone number shown on your ID card.

AVAILABILITY OF TELEPHONE TRIAGE OR SCREENING SERVICES

Triage or screening services are the assessment of a Covered Person's health concerns and symptoms though communication, with a Physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or triage a Covered Person who may need care for the purpose of determining the urgency of the Covered Person's need for medical services. To access triage or screening services you should contact *Customer Care* during normal business hours at the telephone number on your ID card.

In addition to accessing *Customer Care*, you are able to access a registered nurse at Optum's Nurseline, 24 hours per day, 7 days per week by contacting the myNurseline phone number on the back of your ID card or by visiting

www.myuhc.com. Once logged into the myuhc.com portal, the *Ask a Nurse* option will be available, and you may chat online or use the phone number provided to you to speak to a nurse. Optum's Nurseline can help you:

- Chat with a nurse live on myuhc.com.

- Understand treatment options.

- Ask medication questions.

- Choose appropriate medical care.

- Locate available local resources.

- Find a Physician, Hospital or specialist.

Although triage or screening services are available 24 hours per day, 7 days per week, it is not intended to replace or interfere with normal Physician/patient communication.

NETWORK PROVIDER ACCESSIBILITY COMPLAINTS:

If you have a complaint regarding your ability to access Covered Health Services from a Network provider in a timely manner, call Customer Care at the telephone number shown on your ID card. If you would rather send your complaint to us in writing, the Customer Care representative can provide you with the appropriate address. If your complaint is not resolved, you may contact the California Department of Insurance.

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357) if you reside in the State of California

213-897-8921 if you reside outside of the State of California

You may write the California Department of Insurance at:

California Department of Insurance

Consumer Communications Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

ACCESS TO A NETWORK PROVIDER:

If medically appropriate care from a qualified provider cannot be provided within the network, we will arrange for the required care with an available and accessible non-Network provider. You will only be responsible for paying the cost sharing in an amount

equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Service from a Network provider.

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

Selecting a Primary Physician

You may select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Subscriber, in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP.* A Network Primary Physician will be able to coordinate all Covered Health Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you may select a Primary Physician for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network pediatrician as the Primary Physician for an Enrolled Dependent child. You do not need a referral from a Primary Physician and may seek care directly from a Specialist Physician, including a Physician who specializes in obstetrics or gynecology. You have the option of accessing specialists through a Network Primary Physician or self-referring to a Network or non-Network specialist for Covered Health Services. Prior authorization is required for certain Covered Health Services as described under Prior Authorization below.

You may change your Primary Physician by contacting *Customer Care* at the telephone number shown on your ID card.

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

- **Emergency Health Services Provided by a Non-Network Provider -** Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **California Insurance Code §10112.27 requires a health insurer to cover Emergency Health Services in an emergency department of a Hospital without the need for prior authorization, regardless of whether the provider is a Network Provider under the plan, and subject to the same cost sharing required if the services were provided by Network Provider. As a result, you may be responsible for the difference between the amount billed by the non-Network provider and the reimbursement amount that is an Eligible Expense. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**
- **Covered Health Services Provided by a Non-Network Provider that are NOT Emergency Health Services -** Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you may be responsible for the difference between the amount billed by the non-Network facility based Physician and the reimbursement amount that is an Eligible Expense. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

California regulation requires Network facilities to determine and disclose to the Covered Person, prior to the Covered Person receiving nonemergency Covered Health Services, the non-Network providers who are likely to be involved in providing Covered Health Services and the estimated cost of the non-Network providers' care to the Covered Person. This disclosure must be made sufficiently in advance of the scheduled Covered Health Services to afford the Covered Person a reasonable opportunity to explore alternate arrangements. If your Network facility does not make this disclosure sufficiently in advance of a scheduled Covered Health Service to afford the Covered Person a reasonable opportunity to explore

alternate arrangements, the Covered Person should contact us for assistance in exploring alternate arrangements before the scheduled Covered Health Service.

If you disagree with an Eligible Expenses determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Certificate of Coverage. You may also call *Customer Care* at the telephone number on your ID card.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, your Primary Physician and Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

Failure to obtain prior authorization for an essential health benefit as defined under California Insurance Code §10112.27 will not result in a complete loss of coverage or an increase in the cost sharing for that Benefit.

However, failure to obtain prior authorization for certain Covered Health Service delivered by a non-Network provider will result in a penalty of $1,000 per type of service as listed in the Schedule of Benefits table below. Prior authorization is not applicable to Emergency Health Services. The penalty for prior authorization will not exceed the cost of the Benefit to UnitedHealthcare.

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

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. 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 for *Customer Care* **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.

Covered Health Services which Require Prior Authorization

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

- Ambulance - non-emergent air and ground.
- Clinical trials.
- Dental services - accidental.
- Dental anesthesia services.
- Diabetes equipment - insulin pumps over $1,000.
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Gender Dysphoria – surgical services (genital surgery or mastectomy) when a Network provider makes a written referral, and the services requested are Covered Health Services that meet the requirements described in our Gender Dysphoria (Gender Identity Disorder) guideline. Our guideline is available upon request by calling the telephone number for *Customer Care* on your ID card.
- Genetic Testing - BRCA.
- Habilitative Services – Outpatient Therapy and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment, and speech therapy.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery. Prior authorization is not required for Emergency admissions, maternity admissions, and length of Hospital stay following mastectomy and lymph node dissection.
- Infertility services.
- Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.
- Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy, and nuclear medicine, including nuclear cardiology.
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment programs; transcranial magnetic stimulation; and Intensive Behavioral Therapy Treatment. Prior authorization only applies to non-Emergency inpatient admissions.
- Obesity surgery.
- Orthotic devices over $1,000 in cost per device.

- Prosthetic devices over $1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment, and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Specialized footwear over $1,000 in cost per device.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment programs. Prior authorization only applies to non-Emergency inpatient admissions.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.

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 actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that is not a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid. If you have a question regarding a determination of whether a service is Medically Necessary, call the telephone number for *Customer Care* on your ID card. If you disagree with a determination of whether a service is Medically Necessary, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Certificate of Coverage. You may also call *Customer Care* at the telephone number on your ID card.

Care Management

When you seek prior authorization as required, we will work with you to implement 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 Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health 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 Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. **Copayments that are paid in addition to Coinsurance for the following Benefits do not count toward satisfying the Annual Deductible:** • **Congenital Heart Disease Surgeries** • **Hospital - Inpatient Stay** • **Lab, X-Ray and Diagnostics - Outpatient** • **Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient** • **Scopic Procedures - Outpatient Diagnostic and Therapeutic** • **Surgery - Outpatient**	*Network* $750 per Covered Person, not to exceed $1,500 for all Covered Persons in a family. An individual's payment toward the Annual Deductible is limited to the $750 per Covered Person Annual Deductible amount stated above. *Non-Network* $1,500 per Covered Person, not to exceed $3,000 for all Covered Persons in a family. An individual's payment toward the Annual Deductible is limited to the $1,500 per Covered Person Annual Deductible amount stated above.
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
The Out-of-Pocket Maximum is the maximum amount that you will pay per year which includes the Annual Deductible, Copayment and Coinsurance (as applicable). The Out-of-Pocket Maximum excludes Premiums, balance billing amounts for non-Network providers and the Covered Person's spending for non-covered services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Services. • The penalty amount incurred if you do not obtain prior authorization as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	*Network* $5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. An individual's payment toward the Out-of-Pocket Maximum is limited to the $5,500 per Covered Person Out-of-Pocket Maximum amount stated above. After an individual meets this Out-of-Pocket Maximum amount, the Covered Person is no longer responsible for cost sharing for the rest of the year. *Non-Network* $11,000 per Covered Person, not to exceed $22,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. An individual's payment toward the Out-of-Pocket Maximum is limited to the $11,000 per Covered Person Out-of-Pocket Maximum amount stated above. After an individual meets this Out-of-Pocket Maximum amount, the Covered Person is no longer responsible for cost sharing for the rest of the year.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Copayments may never exceed the plan's actual cost of the Covered Health Service. For example, if laboratory tests cost less than a $45 Copayment, the lesser amount is the applicable cost-sharing amount. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you	

Payment Term And Description	Amounts
receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Acupuncture Services			
	Network $20 Copayment per visit *Non-Network* 50%	Yes Yes	No Yes
2. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services for Network or Non-Network Benefits, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per transport.			
Emergency Ambulance	*Network* *Ground Ambulance:* 20% *Air Ambulance:* 20% *Non-Network* *Ground Ambulance:* 20% *Air Ambulance:* 20%	 Yes Yes Yes, Benefits (including but not limited to Coinsurance) for non-Network Emergency ambulance services accrue towards the Network Out-Of-Pocket Maximum. Yes, Benefits (including but not limited to Coinsurance) for	 Yes Yes Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
		non-Network Emergency ambulance services accrue towards the Network Out-Of-Pocket Maximum.	
Non-Emergency Ambulance Ground or air ambulance, as determined to be appropriate.	*Network* *Ground Ambulance:* 20% *Air Ambulance:* 20% *Non-Network* *Ground Ambulance:* 50% *Air Ambulance:* 50%	 Yes Yes Yes, Benefits (including but not limited to Coinsurance) for non-Network Emergency ambulance services accrue towards the Network Out-Of-Pocket Maximum. Yes, Benefits (including but not limited to Coinsurance) for non-Network Emergency ambulance services accrue towards the Network Out-Of-Pocket Maximum.	 Yes Yes Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
3. Clinical Trials			
Prior Authorization Requirement For Network or Non-Network Benefits, you must obtain prior authorization as soon as reasonably possible if participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per trial.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.* Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however if the non-Network provider does not agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.	*Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.* *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
4. Congenital Heart Disease Surgeries			
Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*	*Network* 20% after you pay a Copayment of $250 per Inpatient Stay *Non-Network* Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.
5. Dental Services - Accident Only			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Prior Authorization Requirement For Network and Non-Network Benefits you must obtain prior authorization five business days or as soon as reasonably possible before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per follow-up treatment.			
	Network 20% *Non-Network* Same as Network	Yes Same as Network	Yes Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per item.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	*Network* Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
7. Diabetes Treatment			
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician. Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist	*Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Benefits for diabetes supplies are described in *Section 12: Outpatient Prescription Drug Services* of the *Certificate*.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
the visually impaired, insulin pumps and all related necessary supplies; ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.	*Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. Benefits for diabetes supplies are described in *Section 12: Outpatient Prescription Drug Services* of the *Certificate*.		
8. Durable Medical Equipment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per item.			
	Network 20%	Yes	Yes
	Non-Network 50%	Yes	Yes
9. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital, Network Benefits will not be provided. Non-Network Benefits may	*Network* $100 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The benefits for an Inpatient Stay in a Network	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you may be responsible for the difference between the amount billed by the non-Network provider and the reimbursement amount that is an Eligible Expense. (Please see "Accessing Benefits" at the beginning of this Schedule of Benefits for additional information.)**	Hospital will apply instead. *Non-Network* $100 Copayment per visit. If you are admitted as an inpatient to a non-Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The benefits for an Inpatient Stay in a non-Network Hospital will apply instead.	Yes, Benefits (including but not limited to Copayments) for non-Network Emergency Health Services accrue towards the Network Out-Of-Pocket Maximum.	No
10. Gender Dysphoria			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises. In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this medical *Schedule of Benefits* and in the *Outpatient Prescription Drug Schedule of Benefits.* *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this medical *Schedule of Benefits* and in the *Outpatient Prescription Drug Schedule of Benefits.*		
11. Habilitative Services - Outpatient Therapy and Manipulative Treatment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
reasonably possible. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
Manipulative Treatments are limited to 24 visits per year. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	*Network* $20 Copayment per visit *Non-Network* 50%	Yes Yes	No Yes
12. Hearing Aids			
Limited to $2,500 in Eligible Expenses every year. Benefits are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. This limit does not apply to bone-anchored hearing aids.	*Network* 20% *Non-Network* 50%	Yes Yes	Yes Yes
13. Home Health Care			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
• Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health care aide. • Up to three visits per day (counting all home health care	*Network* 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
visits). • Up to 100 visits per calendar year (counting all home health care visits other than for rehabilitative or habilitative care). • Up to 100 visits per calendar year (counting all home health care visits) for habilitative care. • Up to 100 visits per calendar year (counting all home health care visits) for rehabilitative care. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	*Non-Network* 50%	Yes	Yes
14. Hospice Care			
Prior Authorization Requirement For Non-Network Benefits 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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
	Network 20% *Non-Network* 50%	Yes Yes	Yes Yes
15. Hospital - Inpatient Stay			
Prior Authorization Requirement For Non-Network Benefits 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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
	Network 20% after you pay a Copayment of $250 per Inpatient Stay	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 50% after you pay a Copayment of $250 per Inpatient Stay	Yes	Yes
16. Infertility Services			
Prior Authorization Requirement For Network or Non-Network, you must obtain prior authorization as soon as reasonably possible. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
Limited to $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Schedule of Benefits*. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office* below.	*Network* 20% *Non-Network* 50%	Yes Yes	Yes Yes
17. Lab, X-Ray and Diagnostics - Outpatient			
Prior Authorization Requirement For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
Lab Testing - Outpatient:	*Network* 20% at a freestanding lab or in a Physician's office 20% after you pay a Copayment of $250 per service at an outpatient Hospital-based lab *Non-Network* 50% at a free-standing	Yes Yes	Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	lab or in a Physician's office	Yes	Yes
	50% after you pay a Copayment of $250 per service at an outpatient Hospital-based lab	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	*Network*		
	20% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	20% after you pay a Copayment of $250 per service at an outpatient Hospital-based diagnostic center	Yes	Yes
	Non-Network		
	50% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	50% after you pay a Copayment of $250 per service at an outpatient Hospital-based diagnostic center	Yes	Yes
18. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Prior Authorization Requirement For Non-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy, 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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit.			
	Network		
	20% at a freestanding diagnostic center	Yes	Yes
	20% after you pay a Copayment of $250 per service at an outpatient Hospital-based	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	diagnostic center *Non-Network* 50% at a freestanding diagnostic center 50% after you pay a Copayment of $250 per service at an outpatient Hospital-based diagnostic center	 Yes Yes	 Yes Yes
19. Mental Health Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for and services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions. In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; transcranial magnetic stimulation; Behavioral Health Treatment. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission for an Inpatient Stay or per visit for outpatient services.			
	Network *Inpatient* 20%	 Yes	 Yes
Outpatient Office Visits include: • Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, and medication management.	*Outpatient Office Visits* $20 Copayment per visit	 Yes	 No
All Other Outpatient Treatment include but are not limited to: • Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral	*All Other Outpatient Treatment* 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders delivered at home, outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.	*Non-Network* *Inpatient* 50% *Outpatient Office Visits* 50% *All Other Outpatient Treatment* 50%	Yes Yes Yes	Yes Yes Yes
20. Obesity Surgery			
Prior Authorization Requirement For Covered Health Services required to be received at a Designated Facility and performed by a Designated Physician, you must obtain prior authorization as soon as reasonably possible if obesity surgery arises. If you fail to obtain prior authorization as required, and as a result obesity surgery is not received at a Designated Facility and performed by a Designated Physician, you will incur a penalty of $1,000 per admission. In addition, 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.**			
Obesity surgery must be received at a Designated Facility.	*Network* 20% *Non-Network* Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.
21. Ostomy and Urological Supplies			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	20% *Non-Network* 50%	Yes Yes	Yes Yes
22. Pharmaceutical Products - Outpatient			
	Network 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
23. Physician Fees for Surgical and Medical Services			
Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under *Eligible Expenses* in this *Schedule of Benefits*. **As a result, you may be responsible to the non-Network facility based Physician for any amount billed that is greater than the reimbursement amount that is an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services. (Please see "Accessing Benefits" at the beginning of this Schedule of Benefits for additional information.)**	*Network* 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
24. Physician's Office Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, you will incur a			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	penalty of $1,000 per visit.		
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	*Network* $20 Copayment per visit for a Primary Physician office visit or $40 Copayment per visit for a Specialist Physician office visit *Non-Network* 50%	Yes Yes	No Yes
25. Pregnancy - Maternity Services			
We encourage you to notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that you may enrolled in that are designed to achieve the best outcomes for you and your baby.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Prior Authorization Requirement You may receive obstetrical and gynecological Covered Health Services directly from a Physician without a referral or seeking prior authorization. For Non-Network Benefits 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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
We pay for Covered Health Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is not cost share for this Benefit.	*Network* Benefits will be the same as those stated under each Covered Health 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. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy. The first postnatal/postpartum visit is covered at no charge. Depending upon where the Covered Health Service is provided, Benefits for subsequent postnatal/postpartum care will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. *Non-Network* Benefits will be the same as those stated under each Covered Health 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.		
26. Preventive Care Services			
Physician office services	*Network* No charge	Yes	No
	Non-Network Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.
Lab, X-ray or other preventive tests	*Network* No charge	Yes	No
	Non-Network Non-Network Benefits	Non-Network Benefits are not	Non-Network Benefits are not

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Breast pumps	are not available. *Network* No charge *Non-Network* Non-Network Benefits are not available.	available. Yes Non-Network Benefits are not available.	available. No Non-Network Benefits are not available.
27. Prosthetic Devices			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per device.			
	Network 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
28. Reconstructive Procedures			
Prior Authorization Requirement For Non-Network Benefits 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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per surgery.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Prior Authorization Requirement			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per visit			
Manipulative Treatments are limited to 24 visits per year. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	*Network* $20 Copayment per visit	Yes	No
	Non-Network 50%	Yes	Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20% at a freestanding center	Yes	Yes
	20% after you pay a Copayment of $250 per service at an outpatient Hospital-based center	Yes	Yes
	Non-Network 50% at a freestanding center	Yes	Yes
	50% after you pay a Copayment of $250 per service at an outpatient Hospital-based center	Yes	Yes
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
• Limited to 100 days per benefit period for Skilled Nursing Facility. A benefit period begins on the date the Covered Person is admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date the Covered Person has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after the existing period ends. A prior three-day stay in an acute care Hospital is not required. • Inpatient rehabilitation facility services are unlimited. • Covered Health Services for inpatient habilitative services are unlimited.	*Network* 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
32. Substance Use Disorder Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission for an Inpatient Stay or per visit for outpatient services.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network *Inpatient* 20%	Yes	Yes
Outpatient Office Visits include*:* • Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, and medication management.	*Outpatient Office Visits* $20 Copayment per visit	Yes	No
All Other Outpatient Treatment include but are not limited to*:* • Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, crisis intervention, facility charges for day treatment centers, Intensive Outpatient Programs; outpatient surgery, laboratory charges, or other medical items that fall between inpatient care and regular outpatient office visits.	*All Other Outpatient Treatment* 20%	Yes	Yes
	Non-Network *Inpatient* 50%	Yes	Yes
	Outpatient Office Visits 50%	Yes	Yes
	All Other Outpatient Treatment 50%	Yes	Yes
33. Surgery - Outpatient			
Prior Authorization Requirement For Non-Network Benefits 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 fail to obtain			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
prior authorization as required, you will incur a penalty of $1,000 per surgery.			
	Network 20% at an ambulatory surgical center 20% after you pay a Copayment of $250 per date of service at an outpatient Hospital-based surgical center *Non-Network* 50% at an ambulatory surgical center 50% after you pay a Copayment of $250 per date of service at an outpatient Hospital-based surgical center	 Yes Yes Yes Yes	 Yes Yes Yes Yes
34. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Non-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 fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
35. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Non-Network Benefits 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,			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per treatment.			
	Network 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
36. Transplantation Services			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	*Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.* *Non-Network* Non-Network Benefits are not available.		
37. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*. • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic	*Network* $50 Copayment per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	*Non-Network* 50%	Yes	Yes
38. Virtual Visits			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.	*Network* $20 Copayment per visit *Non-Network* Non-Network Benefits are not available.	Yes Non-Network Benefits are not available.	No Non-Network Benefits are not available.
39. Vision Examinations			
Limited to 1 exam every calendar year. Limited to 2 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aniridia. Limited to 6 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aphakia. This Benefit is limited to adults (age 19 and older). Benefits for routine vision examinations for Covered Persons under age 19 are provided	*Network* $20 Copayment per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
as described in the *Pediatric Vision Care Services Schedule of Benefits* below.	*Non-Network* 50%	Yes	Yes
Additional Benefits Required By California Law			
40. Breast Cancer Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
41. Dental Anesthesia Services			
Prior Authorization Requirement For Non-Network Benefits 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 (including Emergency admissions). If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per admission.			
Services are limited to Covered Persons who are one of the following: • A child under seven years of age. • A person who is developmentally disabled, regardless of age. • A person whose health is compromised and for whom general anesthesia is required, regardless of age.	*Network* 20% *Non-Network* 50%	Yes Yes	Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
42. Enteral Formula and Amino Acid-Modified Food Products			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization before obtaining enteral formula and amino acid-modified food products. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per prescription.			
	Network 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
43. Mastectomy Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
44. Nicotine Use Benefit			
Benefits for nicotine use medications are provided under the *Outpatient Prescription Drug Schedule of Benefits.* Tobacco use and tobacco-related disease counseling and interventions and medications required to be provided under the Preventive Care Services benefit by the *Patient Protection and Affordable Care Act* are not subject to any cost sharing when provided by Network providers.	*Network* 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
45. Off-Label Drug Use and Experimental or Investigational			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
46. Orthotic Benefit			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining orthotic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per device.			
	Network 20% *Non-Network* 50%	Yes Yes	Yes Yes
47. Osteoporosis Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
48. Phenylketonuria (PKU) Treatment			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization before obtaining formulas or special food products for the management and treatment of Phenylketonuria (PKU). If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per prescription.			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit** *(The Amount You Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	20% *Non-Network* 50%	Yes Yes	Yes Yes
49. Specialized Footwear			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining specialized footwear that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, you will incur a penalty of $1,000 per device.			
	Network 20% *Non-Network* 50%	 Yes Yes	 Yes Yes
50. Telehealth Services			
	Network Depending by whom the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Non-Network* Depending by whom the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

Eligible Expenses

Benefits for Covered Health Services are based on Eligible Expenses. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the reimbursement amount that is an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the reimbursement amount that is an Eligible Expense. Eligible Expenses are determined in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
    - Negotiated rates agreed to by the non-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:
        - Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
            - 50% of *CMS* for the same or similar laboratory service.
            - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates
        - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
            - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.uhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
            - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

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

    IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of *CMS* for the same or similar laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (*CMS*) for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

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

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is

available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

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

If medically appropriate care from a qualified provider cannot be provided within the network, we will arrange for the required care with an available and accessible non-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Service from a Network provider.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

If you are undergoing a course of treatment with a Network provider for one of the medical conditions below, and the Network provider caring for you is terminated from the Network by us, we can arrange, at your request and subject to the provider's agreement, for continuation of Covered Health Services rendered by the terminated provider for the time periods shown below. Copayments, deductibles or other cost sharing components will be the same as you would have paid for a provider currently contracting with us.

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

- **An acute condition.** An acute condition is a medical condition that involves a sudden onset of symptoms due to a health condition or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Health Services will be provided for the duration of the acute condition.
- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, health condition or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Health Services will be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Network provider, as determined by us in consultation with the Covered Person and the terminated Network provider and consistent with good professional practice. Completion of Covered Health Services under this provision will not exceed 12 months from termination date of the provider's agreement.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Services will be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Services will be provided for the duration of a terminal illness, which may exceed 12 months from the termination date of the provider's agreement.
- **The care of a newborn child between birth and age 36 months.** Completion of Covered Health Services will not exceed 12 months from the termination date of the provider's agreement.

- **Performance of a surgery or other procedure.** Performance of a surgery or other procedure that has been recommended and documented by the Network provider to occur within 180 days of the termination date of the provider's agreement.

This section does not apply to treatment by a provider or provider group whose contract with us has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health 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 assistance.

Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician or appropriately qualified health care professional. When a second opinion is requested by you or by a Network Physician or health professional that is treating you, we will authorize a second opinion by an appropriately qualified health care professional. The Physician or appropriately qualified health care professional acting within his or her scope of practice, must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment (including, but not limited to, a chronic condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Physician is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the initial treating Physician and still have serious concerns about the diagnosis or treatment.

In most cases, you or your treating Physician or health care professional will request a second medical opinion without consulting us. However, in the event that we approve a request by you for a second medical opinion, you shall be responsible only for the costs of applicable copayments that are required for similar referrals.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Physician or health care professional. It will include any recommended procedures or tests that the Physician or health care professional giving the second opinion believes are appropriate.

Please Note: The fact that an appropriately qualified Physician or health care professional gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is medically necessary or a Covered Health Service. If the recommended action is not medically necessary or is not a Covered Health Service, you will also remain responsible for paying any appropriate fees to the Physician or health care professional that performs that recommended action.

Designated Facilities and Other Providers

If you have a medical condition that needs special services, we may direct you to a Designated Facility and/or a Designated Physician. If you require certain complex Covered Health 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 Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider.

You, your Primary Physician or other Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available or accessible from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Primary Physician or other Network Physician will notify us and, if we confirm that care is not available or accessible from a Network provider, we will work with you and your Primary Physician or other Network Physician to coordinate care through a non-Network provider. If care is authorized from a non-Network provider because it is not available or accessible from a Network provider, you will be responsible for paying only the in-Network cost sharing for the service.

Limitations on Selection of Providers

If you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

If you disagree with a Benefit determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Certificate of Coverage. You may also call *Customer Care* at the telephone number on your ID card.

Pediatric Dental Services Schedule of Benefits

Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from a non-Network provider. Network Benefits are based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

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

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Non-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from non-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from non-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in this *Schedule of Benefits* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this *Schedule of Benefits*.

IMPORTANT: If you opt to receive dental services that are not Covered Dental Services under this *Schedule of Benefits*, a Network Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not Covered Dental Services, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call *Customer Service* at the telephone number on your ID card. To fully understand your coverage, you may wish to carefully review the *Section 10: Pediatric Dental Services* in the *Certificate* and this *Schedule of Benefits.*

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must

provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

If the proposed treatment is a Covered Dental Service, we will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Authorization

Pre-authorization is recommended for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered.

Annual Deductible

Benefits for pediatric Dental Services provided under this *Schedule of Benefits* are subject to the Annual Deductible stated in the medical *Schedule of Benefits*. The Annual Deductible stated in the medical *Schedule of Benefits* does not apply to *Diagnostic Services* and/or *Preventive Services*.

Out-of-Pocket Maximum - Any amount you pay in Coinsurance for pediatric Dental Services under this *Schedule of Benefits* applies to the Out-of-Pocket Maximum stated in the medical *Schedule of Benefits*.

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

Benefit Description

Benefit Description and Limitations	**Network Benefits** **The amount you pay is shown as a percentage of Eligible Dental Expenses.**	**Non-Network Benefits** **The amount you pay is shown as a percentage of Eligible Dental Expenses.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)		
Evaluations (Checkup Exams) *Limited to1 time per 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.* D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D0150 - Comprehensive oral evaluation	No charge	20%
Radiographs (X-ray) *Limited to 1 series of films per 36 months.* D0210 - Complete series	No charge	20%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
(including bitewings) *The following services are not subject to a frequency limit.* D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0250 - Intraoral - occlusal film D0260 - Intraoral - occlusal film *Limited to 2 films per 6 months.* D0240 - Intraoral - occlusal film		
Any combination of the following services is limited to 1 series of films per 6 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films The following services are covered when preformed in a dental setting. When services performed in a medical setting services are covered under your medical coverage. Covered when medically necessary D0290 - Posterior-anterior or lateral skull and facial bone survey radiographic image D0310 - Sialography D0320 - Temporomandibular joint arthrogram, including injection D0322 - Tomographic survey Limited to 1 time per 36 months. D0330 - Panoramic radiograph image	No charge	20%
Any combination of the following services is limited to 2	No charge	20%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
per 12 months. Medically Necessary requirements apply. D0340 - Cephalometric X-ray *Any combination of the following services is limited to 1 per 6 months.* D0350 - Oral/Facial photographic images *The following services are not subject to a frequency limit.* D0460 - pulp vitality tests D0470 - diagnostic casts D0502 - other oral pathology procedures, by report		
Preventive Services - (Not subject to payment of the Annual Deductible.)		
Dental Prophylaxis (Cleanings) *The following services are limited to 1 time every 6 months.* D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	No charge	20%
Fluoride Treatments *The following services are limited to 1 time every 6 months.* D1206 and D1208 - Fluoride	No charge	20%
Sealants (Protective Coating) *The following services are Limited to once per first or second permanent molar every 36 months.* D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	No charge	20%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
Space Maintainers (Spacers) *The following services are Limited to once per quadrant per lifetime.* D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral D1550 - Re-cementation of space maintainer D1555 - Removal of fixed space maintainer	No charge	20%
Minor Restorative Services - (Subject to payment of the Annual Deductible.)		
Amalgam Restorations (Silver Fillings) *The following services are limited as follows:* *Multiple restorations on one surface will be treated as a single filling and limited to 1 per tooth per 12 months* D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	20%	40%
Composite Resin Restorations (Tooth Colored Fillings) *The following services are limited as follows:* *Multiple restorations on one*	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
surface will be treated as a single filling and limited to 1 per tooth per 12 months " D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resign-based composite - four or more surfaces or involving incised angle, anterior D2390 - Resin-based composite crown, anterior D2391 - Resin-based composite - one surface, posterior D2392 - Resin-based composite - two surfaces, posterior D2393 - Resin-based composite - three surfaces, posterior D2394 - Resin-based composite - four or more surfaces, posterior		
Crowns/Inlays/Onlays - (Subject to payment of the Annual Deductible.)		
The following services are subject to a limit of one time every 60 months after 12 months from initial insertion. D2710 - Crown - resin-based composite (indirect) D2712 - Crown - 3/4 resin-based composite (indirect) D2721 - Crown - resin with predominantly base metal	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
D2740 - Crown - porcelain/ceramic substrate D2751 - Crown - porcelain fused to predominately base metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2791 - Crown - full cast predominately base metal *The following service is subject to a limit of one time every 36 months after 12 months from initial insertion.* D2931 - Prefabricated stainless steel crown - permanent tooth *The following services are subject to a limit of one time every 12 months after 12 months from initial insertion.* D2910 - Re-cement inlay D2920 - Re-cement crown D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2930 Prefabricated stainless steel crown - primary tooth D2932 - Prefabricated resin crown D2933 - Prefabricated stainless steel crown with resin window D2980 - Crown repair necessitated by restorative material failure		
The following service is subject to a limit of one per tooth per 6 months. D2940 - Protective restoration	50%	50%
The following services are	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
limited to once time per tooth per lifetime. D2951 - Pin retention - per tooth, in addition to Crown D2952 - Cast post and core in addition to crown D2954 - Prefabricated post and core in addition to crown D2970 - Temporary crown (fractured tooth)		
Endodontics - (Subject to payment of the Annual Deductible.)		
The following services are limited to once time per tooth per lifetime. D3220 - Therapeutic pulpotomy (excluding final restoration) D3221 - Pulpal debridement, primary and permanent teeth D3222 - Partial pulpotomy for apexogenesis - Permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior. primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration)	20%	40%
The following services are not subject to a frequency limit. Initial insertion up to 12 months is not covered by original	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
provide who completed service. D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar		
The following services are limited to once time per tooth per lifetime. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement	20%	40%
The following services are limited to once time per tooth per lifetime. D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root	20%	40%
Periodontics - (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one per quadrant every 36 months. D4210 - - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
teeth D4260 - Osseous surgery D4261 - Osseous surgery (including evaluation of a full thickness flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant		
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	20%	40%
The following service is limited to four times every 12 month. D4910 - Periodontal maintenance	20%	40%
The following service is not subject to a frequency limit. D4920 - Unscheduled dressing change (by someone other than treating dentist or their staff)	20%	40%
Removable Dentures - (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular	50%	50%
The following services are limited to once time per tooth per lifetime. D5130 - Immediate denture - maxillary	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
D5140 - Immediate denture - mandibular		
The following services are limited to a frequency of one every 60 months. D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base	50%	50%
The following services are limited to a frequency of 1 every 6 months. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5660 - Add clasp to existing partial denture	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
The following service is limited to once time per tooth per lifetime. D5650 - Add tooth to existing partial denture *The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months.* D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5741 - Reline mandibular partial denture D5750 - Reline complete maxillary denture (laboratory) D5751 - Reline complete mandibular denture (laboratory) D5760 - Reline maxillary partial denture (laboratory) D5761 - Reline mandibular partial denture (laboratory)	50%	50%
The following services are limited to a frequency of 2 per appliance every 36 months. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
The following service is limited to a frequency of 1 every 60 months. D5860 - Overdenture - complete, by report	50%	50%
Bridges (Fixed Partial dentures) - (Subject to payment of the Annual Deductible.)		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
The following services are limited to a frequency of 1 every 60 months. D6211 - Pontic - case predominately base metal D6241 - Pontic - porcelain fused to predominately base metal D6245 - Pontic - porcelain/ceramic D6251 - Pontic - resin with predominantly base metal D6721 - Crown - resin with predominantly base metal D6740 - Crown - porcelain/ceramic D6751 - Crown - porcelain fused to predominately base metal D6781 - Crown - 3/4 cast predominately base metal D6783 - Crown - 3/4 porcelain/ceramic D6791 - Crown - full cast predominately base metal	50%	50%
The following services are not subject to a frequency limit and not covered if preformed less than 12 months after the initial insertion. D6930 - Re-cement or Re-bond Fixed Partial Denture D6980 - Fixed partial denture repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Annual Deductible.)		
The following services are limited to once time per tooth per lifetime. D7111 - Extraction, coronal	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
remnants - deciduous tooth D7140 - Extraction, erupted tooth or exposed root D7210 - Surgical removal of erupted tooth requiring elevation of mucoperioteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - complete bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7260 - Oroantral fistula closure-upper molar tooth; extract the tooth-create an opening between sinus D7261 - Primary closure of a sinus perforation D7280 - Surgical access of an unerupted tooth D7283 - Placement of device to facilitate eruption of impacted tooth D7290 - Surgical repositioning of teeth		
The following service is limited to 1 per arch per visit. D7285 - Incisional biopsy of oral tissue - hard (bone, tooth)	20%	40%
The following service is limited to 3 per site per visit. D7286 - Incisional biopsy of oral tissue - soft	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
The following service is limited to 1 per arch per lifetime. D7291 - Transseptal fiberotomy/supra crestal fiberotomy, by report	20%	40%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant	20%	40%
The following service is not subject to a frequency limit and is not covered within 6 months following extractions in the same quadrant. D7320 - Alveoloplasty not in conjunction with extractions - per quadrant	20%	40%
The following service is not subject to a frequency limit. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	20%	40%
The following service is limited to 1 per arch per 60 months. D7340 - Vestibuloplasty - ridge extension (secondary epithelialization)	20%	40%
The following service is limited to 1 per arch per lifetime. D7350 - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
The following services are not subject to a frequency limit. D7410 - Excision of benign lesion up to 1.25 cm D7411 - Excision of benign lesion greater than 1.25 cm D7412 - Excision of benign lesion, complicated D7413 - Excision of malignant lesion up to 1.25 cm D7414 - Excision of malignant lesion greater than 1.25 cm D7415 - Excision of malignant lesion, complicated D7440 - Excision of malignant tumor-lesion diameter up to 1.25 cm D7441 - Excision of malignant tumor - lesion diameter greater than 1.25 cm D7450 - Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm D7451 - Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm D7460 - Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm D7461 - Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	20%	40%
The following services are covered when preformed in a dental setting. When services performed in a medical setting services are covered under your medical coverage. Covered when medically	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
necessary D7465 - Destruction of lesion(s) by physical or chemical method, by report D7490 - Radical resection of maxilla or mandible		
The following services are limited to 1 per quadrant per lifetime. D7471 - removal of lateral exostosis (maxilla or mandible) D7472 - Removal of torus palatinus D7473 - Removal of torus mandibularis D7485 - Surgical reduction of osseous tuberosity D7510 - Incision and drainage of abscess - intraoral soft tissue D7511 - Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20%	40%
The following services are not subject to a frequency limit. D7520 - Incision and drainage of abscess - extraoral soft tissue D7521 - Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20%	40%
The following services are limited to 1 per quadrant per visit. D7530 - Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue D7540 - Removal of reaction-	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
producing foreign bodies - musculoskeletal system D7550 - Partial ostectomy/sequestrectomy for removal of non-vital bone D7560 - Maxillary sinusotomy for removal of tooth fragment or foreign body D7960 - Frenulectomy (frenectomy or frenotomy) - separate procedure D7963 - Frenuloplasty D7970 - Excision of hyperplastic tissue - per arch D7972 - Surgical reduction of fibrous tuberosity D7997 - Appliance removal (not by dentist who placed appliance), includes removal of archbar		
The following services are covered when preformed in a dental setting. When services performed in a medical setting services are covered under your medical coverage. Covered when medically necessary D7610 - Maxilla - open reduction (teeth immobilized, if present) D7620 - Maxilla - closed reduction (teeth immobilized, if present) D7630 - Mandible - open reduction (teeth immobilized, if present) D7640 - Mandible - closed reduction (teeth immobilized, if present) D7650 - Malar and/or zygomatic arch - open	50%	50%.

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
reduction D7660 - Malar and/or zygomatic arch - closed reduction D7670 - Alveolus - closed reduction, may include stabilization of teeth D7671 - Alveolus - open reduction, may include stabilization of teeth D7680 - Facial bones - complicated reduction with fixation and multiple surgical approaches D7710 - Maxilla - open reduction D7720 - Maxilla - closed reduction D7730 - Mandible - open reduction D7740 - Mandible - closed reduction D7750 - Malar and/or zygomatic arch - open reduction D7760 - Malar and/or zygomatic arch - closed reduction D7770 - Alveolus, open reduction stabilization of teeth D7771 - Alveolus, closed reduction stabilization of teeth D7780 - Facial bones - complicated reduction with fixation and multiple surgical approaches D7810 - Open reduction of dislocation D7820 - Closed reduction of dislocation D7840 - Condylectomy		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
D7850 - Surgical discectomy, with/without implant D7852 - Disc repair D7854 - Synovectomy D7856 - Myotomy D7858 - Joint reconstruction D7860 - Arthrotomy D7865 - Arthroplasty D7870 - Arthrocentesis D7872 - Arthroscopy - diagnosis, with or without biopsy D7873 - Arthroscopy - surgical: lavage and lysis of adhesions D7874 - Arthroscopy - surgical: disc repositioning and stabilization D7875 - Arthroscopy - surgical: synovectomy D7876 - Arthroscopy - surgical: discectomy D7877 - Arthroscopy - surgical: debridement D7880 - Occlusal orthotic device, by report D7911 - Complicated suture - up to 5 cm D7912 - Complicated suture - greater than 5 cm D7920 - Skin graft (identify defect covered, location and type of graft) D7940 - Osteoplasty - for orthognathic deformities D7941 - Osteotomy - mandibular rami D7943 - Osteotomy - mandibular rami with bone graft; includes obtaining the		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
graft D7944 - Osteotomy - segmented or subapical - per sextant or quadrant D7945 - Osteotomy - body of mandible D7946 - LeFort I (maxilla - total) D7947 - LeFort I (maxilla - segmented) D7948 - LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft D7949 - LeFort II or LeFort III - with bone graft D7950 - Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report D7951 - Sinus augmentation with bone or bone substitutes D7952 - Sinus augmentation via a vertical approach D7955 - Repair of maxillofacial soft and/or hard tissue defect D7980 - Sialolithotomy D7981 - Excision of salivary gland, by report D7982 - Sialodochoplasty D7983 - Closure of salivary fistula D7990 - Emergency tracheotomy D7991 - Coronoidectomy D7995 - Synthetic graft - mandible or facial bones, by report D7997 - Appliance removal (not		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
by dentist who placed appliance), includes removal of archbar D9410 - House/extended care facility call D9420 - Hospital call D9440 - Office visit for observation (during regularly scheduled hours) - no other services performed		
The following service is limited to 1 per site every 36 months. D7971 - Excision of pericoronal gingiva	20%	40%
Adjunctive Services - (Subject to payment of the Annual Deductible.)		
The following services are not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure D9120 - Fixed partial denture sectioning D9210 - Local anesthesia not in conjunction with operative or surgical procedures	20%	40%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis D9241 - Intravenous conscious	20%	40%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9248 - Non-intravenous moderate (conscious) sedation D9430 - Office visit for observation (during regularly scheduled hours) - no other services performed D9610 - Therapeutic drug injection, by single report D9610 - Therapeutic drug injection, single by report D9910 - Application of desensitizing medicament D9930 - Treatment of complications (post-surgical) - unusual circumstances, by report		
The following services are limited to 1 per quadrant every 12 months. D9950 - Occlusion analysis - mounted case D9951 - Occlusal adjustment - limited D9952 - Occlusal adjustment - complete	20%	40%
Implant Procedures - (Subject to payment of the Annual Deductible.)		
The following services are limited to one time every 60 months. D6010 - Endosteal implant D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6051 - Interim abutment	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment - includes placement D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
high noble metal fixed partial denture D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture D6077 - Implant supported retainer for cast metal fixed partial denture D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch D6080 - Implant maintenance procedure D6090 - Repair implant prosthesis D6091 - Replacement of semi-precision or precision attachment		

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
D6094 - Abutment supported crown (titanium) D6095 - Repair implant abutment D6190 - Implant index D6194 - Abutment supported retainer crown for FPD - (titanium)		
The following services are limited to one time every 60 months and not covered if preformed within the first 12 months of placement. D6092 - Re-cement or re-bond implant/abutment supported crown D6093 - Re-cement or re-bond implant/abutment supported fixed partial denture	50%	50%
The following service is not subject to a frequency limit. D6100 - Implant removal	50%	50%
MEDICALLY NECESSARY ORTHODONTICS - (Subject to payment of the Annual Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bit. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been	50%	50%

Benefit Description and Limitations	Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits The amount you pay is shown as a percentage of Eligible Dental Expenses.
prior authorized. D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8090 - Comprehensive orthodontic treatment of the adult dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8691 - Repair of orthodontic appliance D8692 - Replacement of lost or broken retainer D8693 - Re-cement or re-bonding or re-cementing of fixed retainers		

Pediatric Vision Care Services Schedule of Benefits

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim* and in the *Certificate* in *Section 11: Pediatric Vision Services* under *Claims for Vision Care Services*. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you may be required to pay a Copayment at the time of service.

Network Benefits:

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

Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - Any amount you pay in Coinsurance for Vision Care Services under this *Schedule of Benefits* applies to the Out-of-Pocket Maximum stated in the medical *Schedule of Benefits*. Any amount you pay in Copayments for Vision Care Services under this *Schedule of Benefits* applies to the Out-of-Pocket Maximum stated in the medical *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this *Schedule of Benefits* are not subject to any Annual Deductible stated in the medical *Schedule of Benefits*.

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

Frequency of Service Limits

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

Vision Care Service	**Frequency of Service**	**Network Benefit** *(The Amount You Pay)*	**Non-Network Benefit** *(The Amount You Pay)*
Routine Opthalmologic Exam with Refraction (including dilation, if professionally indicated).	Once every calendar year.	No charge	50% of the billed charge.

Vision Care Service	**Frequency of Service**	**Network Benefit** *(The Amount You Pay)*	**Non-Network Benefit** *(The Amount You Pay)*
Eyeglass Lenses	One pair every calendar year.		
• *Single Vision*		20%	50% of the billed charge.
• *Bifocal*		20%	50% of the billed charge.
• *Trifocal*		20%	50% of the billed charge.
• *Lenticular*		20%	50% of the billed charge.
• *Polycarbonate Lenses*		No charge	No charge
• *Standard Scratch-Resistant Coating*		No charge	No charge
• *Blended Segment Lenses*		20%	Non-Network Benefits are not available.
• *Intermediate Vision Lenses*		20%	Non-Network Benefits are not available.
• *Progressive Lenses* ▪ *Standard* ▪ *Premium* ▪ *Select* ▪ *Ultra*		20%	Non-Network Benefits are not available.
• *Photochromic Glass Lenses*		20%	Non-Network Benefits are not available.
• *Plastic Photosensitive Lenses*		20%	Non-Network Benefits are not available.
• *Polarized Lenses*		20%	Non-Network Benefits are not available.
• *Hi-Index Lenses*		20%	Non-Network Benefits are not available.

• *Anti-Reflective Coating* ▪ *Standard* ▪ *Premium* ▪ *Ultra*		20%	Non-Network Benefits are not available.
• *Ultra Violet Coating*		20%	Non-Network Benefits are not available.

Vision Care Service	**Frequency of Service**	**Network Benefit** *(The Amount You Pay)*	**Non-Network Benefit** *(The Amount You Pay)*
Eyeglass Frames	One pair per calendar year.	20%	50% of the billed charge.

Vision Care Service	**Frequency of Service**	**Network Benefit** *(The Amount You Pay)*	**Non-Network Benefit** *(The Amount You Pay)*
Contact Lenses (in lieu of eyeglasses) Benefits include the fitting/evaluation fees, contacts and follow-up care.	One year supply.		
• *Covered Contact Lens Selection*		20%	50% of the billed charge.
• *Necessary Contact Lenses*		20%	50% of the billed charge.

Vision Care Service	**Frequency of Service**	**Network Benefit** *(The Amount You Pay)*	**Non-Network Benefit** *(The Amount You Pay)*
Low Vision Services			
• *Low Vision Comprehensive Evaluation*	Once every 24 months.	No charge	25% of the billed charge.

• *Low Vision Follow-up Care*	Four visits in any 5 year period.	25%	25% of the billed charge.
• *Low vision aid such as high-power spectacles, magnifiers and telescopes*	Once every 12 months.	25%	25% of the billed charge.

Outpatient Prescription Drug Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.

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

- Prescription Drug Products prescribed to prevention conception include, but are not limited to, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- FDA-approved over-the-counter contraceptives for women when prescribed by a Network Physician include, but are not limited to, female condoms, emergency contraceptives (Next Choice™, Next Choice One-Dose™, Plan B One-Step®), and contraceptive film, foam and gel.
- Disposable devices which are Medically Necessary for the administration of a covered outpatient Prescription Drug Product, including but not limited to:
  - Disposable needles and syringes needed for injecting Prescription Drug Products.
  - Inhaler spacers need to inhale Prescription Drug Products.
- Benefits for drugs prescribed for the treatment of sexual dysfunction disorders.
- Benefits for drugs prescribed to treat HIV/AIDS, including some single-tablet drug regimens, as mandated by California state law.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient i*n your Certificate of Coverage, regardless of tier placement. For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed $200 for an individual prescription of up to a 30-day supply.

If 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, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

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 Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Some Prescription Drug Products require prior authorization. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, either 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 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 Physician.

If you are taking a Prescription Drug Product that is removed from the Prescription Drug List (PDL) and the prescribing provider continues to prescribe the Prescription Drug Product for your medical condition, we will continue to cover the Prescription Drug Product provided that the drug is appropriately prescribed and is considered safe and effective for treating your medical condition.

If a contraceptive listed on the Prescription Drug List (PDL) is not available, or is deemed medically inadvisable by the Covered Person's provider, we will provide coverage for a contraceptive that is not listed on the PDL without cost sharing.

A Covered Person or his/her provider may request an exception to the supply limits for Prescription Drug Products. We will provide coverage for the Medically Necessary dosage and quantity of the Prescription Drug Product prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

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.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

Most authorizations are completed within 24 hours. If required, a further clinical review will be completed in 72 hours of receipt of the request. In the event that the prior authorization request is disapproved by us, the notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the prior authorization request.

In cases involving Prescription Drug Products for appropriately prescribed pain management medications for terminally ill patients, we will approve or deny the prescribing provider's request in a timely fashion, appropriate for the nature of the Covered Person's condition, not to exceed 72 hours of our receipt of the information requested by us. If the request is denied or additional information is required, we will contact the prescribing provider within one working day of the decision, with an explanation of the reason for the denial or the need for additional information. The requested treatment will be deemed authorized as of the expiration of the applicable timeframe.

Prescription Drug Products not included on the Prescription Drug List (PDL) may be generic or brand name drugs and require prior authorization. Your prescribing provider must obtain prior authorization from us for drugs that are not included on the Prescription Drug List (PDL). Prescription Drug Products not included on the Prescription Drug List (PDL) will be covered when Medically Necessary unless otherwise excluded by us as described in *Section 12: Outpatient Prescription Drug Services* of the *Certificate*. If

your prescribing provider does not obtain authorization for drugs not on the Prescription Drug List (PDL), they will not be covered.

The process for the Covered Person, the Covered Person's designee, or the Covered Person's prescribing provider to request a standard review of a decision that a Prescription Drug Product is not included on the Prescription Drug List (PDL) is as follows:

- **In the case of a standard exception request**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. When we grant a standard exception request, we will provide coverage of the Prescription Drug Product for the duration of the prescription, including refills.
- **In the case of an expedited exception request based on exigent circumstances**, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. When we grant an exception based on exigent circumstances, we will provide coverage of the Prescription Drug Product (including refills) for the duration of the exigency. Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when the Covered Person is undergoing a current course of treatment using a Prescription Drug Product that is not on the Prescription Drug List (PDL).
- **External exception request review.** If we deny a request for a standard exception or for an expedited exception, the Covered Person, the Covered Person's designee, or the Covered Person's prescribing provider may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. A denial of a request for an exception is subject to Independent Medical Review (IMR). The IMR process is described under *Section 6: Questions, Complaints and Appeals*. The Independent Medical Review Organization will make a determination on the external exception request and notify the Covered Person or the Covered Person's designee and the prescribing provider of the Benefit determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. If the Independent Medical Review Organization grants an external exception review of a standard exception request, we will provide coverage of the Prescription Drug Product that is not on the Prescription Drug List (PDL) for the duration of the prescription. If the Independent Medical Review Organization grants an external exception review of an expedited exception request, we will provide coverage of the Prescription Drug Product that is not on the Prescription Drug List (PDL) for the duration of the exigency.

The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Certain Prescription Drug Products may require authorization prior to dispensing or may not be covered. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you will be required to pay for the Prescription Drug Product at the 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, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available if the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service. You can request an appeal of a denial of Benefits.

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 associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you disagree with a determination, you can request an appeal. The complaint and appeals process, including independent medical review, is described in the *Certificate of Coverage* under *Section 6: Questions, Complaints and Appeals*. You may also call *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Schedule of Benefits or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements.

Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating the Covered Person's condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate.

If the Covered Person's Physician determines that a Prescription Drug Product or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating the Covered Person's condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com.

If the Covered Person is changing policies, we will not require the Covered Person to repeat step therapy when the Covered Person is already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Covered Person's medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Covered Person's medical condition.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in *Prior Authorization Requirements* of this *Outpatient Prescription Drug Schedule of Benefits*.

What You Must Pay

You are not responsible for paying the Annual Deductible stated in the medical *Schedule of Benefits* before Benefits for Prescription Drug Products are available to you.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for 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 Annual Deductible or Out-of-Pocket Drug Maximum.

The amount you pay for any of the following under this *Schedule of Benefits* will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- The difference between the Predominant Reimbursement Rate and a non-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 and our contracted rates (our Prescription Drug Charge) will not be available to you.
- Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.

Payment Information

Payment Term And Description	Amounts
Infertility Maximum Policy Benefit	
The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.	$2,000 per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. *Coinsurance* Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. *Copayment and Coinsurance* Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription 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 Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. You are not responsible for paying a Copayment and/or Coinsurance for FDA-approved over-the-counter contraceptives for women as described under Benefits for *Prescription Drug Products* above.

Benefit Information

Description and Supply Limits	Benefit (The Amount You Pay)
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. 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 Copayment and/or Coinsurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance 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 through the Internet at www.myuhc.com or by calling *Customer Care* at 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 Copayment and/or 2 times the Preferred Specialty Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. *Network Pharmacy* For a Tier 1 Prescription Drug Product: $15 Copayment per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 Copayment per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 Copayment per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% of the Prescription Drug Charge per Prescription Order or Refill and you will not pay more than $250 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed $200 for an individual prescription of up to a 30-day supply. *Non-Network Pharmacy* For a Tier 1 Prescription Drug Product: $15 Copayment per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 Copayment per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 Copayment per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% of the Predominant Reimbursement Rate per Prescription Order or Refill and you will not pay more than $250 per Prescription Order or Refill. For oral chemotherapeutic agents on any Tier, the total amount of Copayments and/or Coinsurance shall not exceed $200 for an individual prescription of up to a 30-day supply.

Description and Supply Limits	Benefit (The Amount You Pay)
Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	
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 Copayment and/or Coinsurance for each cycle supplied. You are not responsible for paying a Copayment and/or Coinsurance for Prescription Drug Products prescribed to prevent conception that are considered Preventive Care Medications. If you disagree with a coverage determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Certificate of Coverage. You may also call *Customer Care* at the telephone number on your ID card. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: $15 Copayment per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 Copayment per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 Copayment per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% of the Prescription Drug Charge per Prescription Order or Refill and you will not pay more than $250 per Prescription Order or Refill.
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply:	Your Copayment and/or Coinsurance is determined by the tier to which

Description and Supply Limits	Benefit (The Amount You Pay)
• 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 Copayment and/or Coinsurance for each cycle supplied. You are not responsible for paying a Copayment and/or Coinsurance for Prescription Drug Products prescribed to prevent conception that are considered Preventive Care Medications. If you disagree with a coverage determination, you can request an appeal. The complaint and appeals process is described under *Section 6: Questions, Complaints and Appeals* in the Certificate of Coverage. You may also call *Customer Care* at the telephone number on your ID card. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: $15 Copayment per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 Copayment per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $60 Copayment per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% of the Predominant Reimbursement Rate per Prescription Order or Refill and you will not pay more than $625 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order 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 Pharmacy are subject to	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status. For up to a 90-day supply, you pay: For a Tier 1 Prescription Drug Product: $37.50 Copayment per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 Copayment per Prescription Order or Refill.

Description and Supply Limits	Benefit (The Amount You Pay)
the supply limits stated above under the heading *Specialty Prescription Drug Products*. You may be required to fill an initial Prescription Drug Product order and obtain 2 refills through a retail pharmacy prior to 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 mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	For a Tier 3 Prescription Drug Product: $150 Copayment per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 25% of the Prescription Drug Charge per Prescription Order or Refill and you will not pay more than $250 per Prescription Order or Refill.