UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-357-1371

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

UnitedHealthcare Non-Differential PPO

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders, if additional Covered Health Services not described in this *Certificate* are purchased by the Enrolling Group.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. If there are material changes in any of the terms of the Policy, UnitedHealthcare will provide sixty (60) days advance notice to the Enrolling Group. The Enrolling Group shall be responsible for delivering the notice to all Covered Persons and to other persons eligible for coverage.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

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

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of California. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of California are the laws that govern the Policy.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

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

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. You are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

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

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

Our administrative function regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received is based on this contract and is subject to the other terms, limitations and exclusions set out in this *Certificate* and *Schedule of Benefits*. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will do the following:

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

Other persons or entities may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in accordance with one or more of the following methodologies:

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

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

Offer Health Education Services to You

We provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. We offer a variety of health education counseling programs and materials, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a health condition, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

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

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Acupuncture Services

Acupuncture services for the treatment of a health condition. Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

2. Ambulance Services

Emergency:

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed. Benefits for emergency ambulance transportation are available and do not require prior authorization in the following situations:

- A reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance services.
- The treating Physician determines that the Covered Person must be transported to another facility because the Emergency medical condition is not stabilized and the care the Covered Person requires is not available at the treating facility.

For purposes of this Benefit, "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- placing the Covered Person's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
  - there is inadequate time to effect safe transfer to another Hospital prior to delivery, or
  - a transfer poses a threat to the health and safety of the Covered Person or unborn child.

An Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Covered Person as being either of the following:

- An immediate danger to himself or herself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Non-Emergency:

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) and psychiatric transport van services when the vehicle transports the Covered Person to or from Covered Health Services and the use of other means of transportation may endanger the Covered Person's health.

3. Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other Life-Threatening disease or condition.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is:

- Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition, or
- Either:
  - the referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon his/her meeting the conditions that are eligible for the clinical trial, or

- the Covered Person provides medical and scientific information establishing that his/her participation in such trial would be appropriate based upon the individual meeting the conditions that are eligible for the clinical trial.

Routine patient care costs for qualifying clinical trials include:

- With respect to a clinical trial for the treatment of cancer, the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be Covered Health Services under the Policy if those drugs, items, devices and services were not provided in connection with an approved clinical trial program.
- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s), drug, item or device, the clinically appropriate monitoring of the effects of the Experimental or Investigational Service(s), drug, item or device or the prevention of complications arising from the provision of the Experimental or Investigational Service(s), drug, item or device.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational, drug, item, device or service, including the diagnosis of treatment of the complications.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening disease or condition, including involving a drug that is exempt under federal regulations from a new drug application, and which meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.

- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

With respect to a clinical trial for the treatment of cancer, 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 Covered Person enrolling in the trial, you will be responsible for the difference and may be billed by the non-Network provider.

4. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the health condition and if extenuating circumstances exist due to the severity of the health condition.)

Please note that dental damage that occurs as a result of normal activities of daily living, such as chewing and/or biting, or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by the accidental health condition must conform to the following time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of the accidental health condition are limited to the following:

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

6. Diabetes Services

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

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

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

7. Diabetes Treatment

Diabetes equipment and supplies are limited to blood glucose monitors and blood glucose testing strips or reagent strips for home blood glucose monitors, interstitial glucose monitors, blood glucose monitors designed to assist the visually impaired, replacement batteries for home blood glucose monitors, insulin pumps and all related necessary supplies; infusion sets for external insulin pumps, ketone urine testing strips, lancets and lancet puncture devices, spring-powered device for lancet, calibrator solution/chips, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, syringe with needle for insulin pump, visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

8. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair, canes and crutches. Benefits for canes and crutches include adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Benefits for enteral and parenteral nutrition include enteral feeding supply kits; enteral nutrition infusion pump, enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; stomach tube; and supplies for self-administered injections.
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage). Benefits for respiratory drug delivery devices include large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; and water collection device for nebulizer.
- Nebulizers, including faces masks and tubing, and peak flow meters when Medically Necessary for the management and treatment of pediatric asthma.
- Insulin pumps and all related necessary supplies as described under *Diabetes Treatment*.
- Infusion pumps and related supplies. Benefits include external single or multiple channel electric or battery-operated ambulatory infusion pumps; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion supplies for external drug infusion pumps; single or multi-channel stationary parenteral infusion pumps; and replacement batteries for infusion pumps.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.
- Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to a health condition. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits for tracheostomy equipment include artificial larynx; replacement battery for artificial larynx; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze sterile water, waterproof tape, and tracheostomy care kits.

- Osteogenesis Stimulation Devices. Benefits include non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
- Non-segmental home model pneumatic compressor for the lower extremities; cervical traction equipment (over door); phototherapy (bilirubin) light with photometer; dry pressure pad for a mattress; and IV pole.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

9. Emergency Health Services - Outpatient

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

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

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

10. Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services*.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) as provided under the *Pharmaceutical Products - Outpatient* Benefit.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as provided in *Section 12: Outpatient Prescription Drug Services.*
  - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

11. Habilitative Services - Outpatient Therapy and Manipulative Treatment

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

Benefits will be available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service is not "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons when the following condition is met:

- The initial or continued treatment must not be an Unproven Service or Experimental or Investigational. This condition does not apply to Medically Necessary occupational therapy or speech therapy for a Covered Person with a diagnosis of pervasive developmental disorder or Autism Spectrum Disorder.

Benefits for habilitative services will be covered under the same terms and conditions applied to rehabilitative services under the Policy. Habilitative services include the outpatient rehabilitation services listed below:

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

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Benefits for habilitative services provided during an Inpatient Stay are a Covered Health Service as described under *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.*

12. Hearing Aids

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

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

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

13. Home Health Care

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

- Ordered by a Physician.
- Provided in your home by a registered nurse, medical social workers, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits include rehabilitation, physical, occupational or other therapy as Medically Necessary.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It requires clinical training in order to be delivered safely and effectively.

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.

14. Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Covered Person experiencing the last phases of life due to a terminal illness. Hospice care also provides support to the primary care giver and the family of the Covered Person. A Covered Person who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness.

Benefits are available if all of the following requirements are met:

- A Physician has diagnosed the Covered Person with a terminal illness. For purposes of this Benefit, a terminal illness is a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.
- Covered Health Services must be received from a licensed hospice agency.
- Covered Health Services are necessary for the palliation and management of the Covered Person's terminal illness and related conditions.

Benefits include the following Covered Health Services on a 24 hour basis to the extent necessary to meet the needs of the Covered Person:

- Interdisciplinary team care with development and maintenance of an appropriate plan of care.
- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
- Bereavement services.

- Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, will also be provided when necessary.
- Services provided by a Physician who is charged with the responsibility of acting as a consultant to the interdisciplinary team and for meeting the general medical needs of the Covered Person to the extent that those needs are not met by the attending Physician.
- Volunteer services.
- Short-term Inpatient Stay arrangements.
- Prescription Drug Products, medical equipment and supplies which are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical therapy, occupational therapy and speech therapy for purposes of symptom control or to enable the Covered Person to maintain activities of daily living and basic functional skills.
- Respite care when necessary to relieve the family members or other persons caring for the Covered Person. Benefits for respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

Benefits are also available for the following Covered Health Services during periods of crisis. A period of crisis is a period in which the Covered Person requires continuous care to achieve palliation or management of acute medical symptoms.

- Nursing care services on a continuous basis for as much as 24 hours a day as necessary to maintain a Covered Person at home.
- Short-term Inpatient Stay required a level that cannot be provided at home.

15. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Room and board, including a private room as Medically Necessary.
- Meals, including special diets as Medically Necessary.
- General nursing care and specialty duty nursing care as Medically Necessary.
- Operating room and recovery rooms.
- Intensive care unit and services.
- Prescription Drug Products, biologicals, anesthesia and oxygen services.
- Diagnostic laboratory and x-ray services.
- Physical therapy.
- Respiratory therapy.
- Administration of blood and blood products.
- Other diagnostic, therapeutic and rehabilitative services as appropriate.
- Coordinated discharge planning, including the planning of continuing care as necessary.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

16. Infertility Services

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

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

For purposes of this Benefit, infertility means either:

- the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of infertility, or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

In order to be eligible for Benefits, the Covered Person must also have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

17. Lab, X-Ray and Diagnostics - Outpatient

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

- Lab and radiology/X-ray.
- Mammography. Benefits are provided whether mammography testing is ordered or referred by a Physician, a nurse practitioner or a certified nurse midwife.
- All generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services*.)

Benefits under this section include:

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

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

18. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Covered Health Services under this section include all generally medically accepted cancer screening tests that are performed for diagnostic reasons. (Cancer screenings for preventive care are described under *Preventive Care Services*.)

Benefits under this section include:

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

19. Mental Health Services

Benefits for Mental Health Services include Covered Health Services for the diagnosis and treatment of Mental Illnesses. Mental Illness is defined as those mental health or psychiatric diagnostic categories that

are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- All other outpatient items and services include Partial Hospitalization/Day Treatment, outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Prescription drugs.

Benefits for Covered Health Services provided on an outpatient basis are separated into the following two (2) categories in the *Schedule of Benefits* for the purpose of establishing the cost share that applies to the Benefit:

- *Outpatient Office Visits:*
    - Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, and medication management.
- *All Other Outpatient Treatment:*
    - Partial Hospitalization/Day Treatment, Multidisciplinary Intensive Outpatient Psychiatric Treatment, facility charges for day treatment centers; Intensive Outpatient programs; crisis intervention, Behavioral 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.

Benefits under this section also include the diagnosis and all Medically Necessary treatment of Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child under the same terms and conditions that apply to medical conditions as required by California insurance law. This includes, but is not limited to, Copayments and deductibles.

Covered Health Services provided for Severe Mental Illness of a Covered Person of any age and Serious Emotional Disturbances of an Enrolled Dependent child must meet the definitions of Severe Mental Illness or Serious Emotional Disturbances as defined in this *Certificate* in *Section 9: Defined Terms*.

Benefits include Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders under the same terms and conditions that apply to medical conditions. Medically Necessary Behavioral Health Treatment will not be denied or unreasonably delayed:

- Based on an asserted need for cognitive or intelligence quotient (IQ) testing;
- On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
- On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

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

20. Obesity Surgery

Benefits for obesity surgery are available when Covered Health Services are performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption when a Physician, who is a specialist in obesity surgery, determines that the surgery is Medically Necessary. Benefits also include non-surgical medical treatment, such as weight loss programs and outpatient prescription drugs, when Medically Necessary for the treatment of morbid obesity.

Benefits for Obesity Surgery Travel Services:

If you live 50 miles or more from the Designated Facility to which you are referred for obesity surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from us and send us adequate documentation, including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other *Certificate* offered by your Enrolling Group.
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other *Policy* offered by your Enrolling Group.
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other *Policy* offered by your Enrolling Group.
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other *Policy* offered by your Enrolling Group.

21. Ostomy and Urological Supplies

Benefits for ostomy supplies and for urological supplies are limited to the following:

- **Ostomy supplies:** adhesives, adhesive remover, ostomy belt, hernia belts, catheter, skin wash/cleaner, bedside drainage bag and bottle, urinary leg bags, gauze pads, irrigation faceplate, irrigation sleeve, irrigation bag, irrigation cone/catheter, lubricant, urinary connectors, gas filters, ostomy deodorants, drain tube attachment devices, gloves, stoma caps, colostomy plug, ostomy

inserts, urinary and ostomy pouches, barriers, pouch closures, ostomy rings, ostomy face plates, skin barrier, skin sealant, and waterproof and non-waterproof tape.

- **Urological supplies:** adhesive catheter skin attachment, catheter insertion trays with and without catheter and bag, male and female external collecting devices, male external catheter with integral collection chamber, irrigation tubing sets, indwelling catheters, foley catheters, intermittent catheters, cleaners, skin sealants, bedside and leg drainage bags, bedside bag drainage bottle, catheter leg straps, irrigation tray, irrigation syringe, lubricating gel, sterile individual packets, tubing and connectors, catheter clamp or plug, penile clamp, urethral clamp or compression device, waterproof and non-waterproof tape, and catheter anchoring device.
- **Incontinence supplies for hospice patients:** disposable incontinence underpads and adult incontinence garments.

22. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

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

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

23. Physician Fees for Surgical and Medical Services

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

24. Physician's Office Services

Services provided in a Physician's office for the diagnosis and treatment of a health condition. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

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

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Benefits under this section include routine physical examinations. Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

25. Pregnancy - Maternity Services

Benefits for Pregnancy include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

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

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

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

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

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

When the mother and child are discharged early, coverage is provided for at least one post discharge follow-up visit within 48 hours of discharge, when prescribed by the treating Physician. A post discharge visit must be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit includes, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating Physician, in consultation with the mother, will determine whether the post discharge visit occurs at home, a birth facility, or the treating Physician's office. Prenatal diagnosis and counseling for genetic disorders are covered.

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 no cost share for this Benefit.

26. Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including cancer screening tests and counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions. Tobacco use and tobacco-related disease counseling and interventions include a minimum of eight counseling sessions of at least 10 minutes each. Screening tests for heredity breast and ovarian cancer are covered as a preventive care service when they are an "A" or "B" recommendation of the *United States Preventive Services Task Force.*

- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including FDA approved AIDS vaccine if recommended by the *United States Public Health Services.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*, including screening for blood lead levels, Phenylketonuria (PKU) testing, periodic health evaluations, and laboratory services in connection with periodic health evaluations.

  Benefits are also provided for wellness examinations (well-baby, well-child) in accordance with the *American Academy of Pediatrics* and *American Academy of Family Physicians* age and frequency guidelines and include:

  - Screening newborns for hearing problems, thyroid disease, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
  - For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders.
  - Screening and counseling for obesity in children and adolescents, age 6-18 years old. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including comprehensive, intensive behavioral interventions to promote improvement in weight status.

  Benefits for preventive care for children will be consistent with both of the following:

  - The *Recommendations for Preventive Pediatric Health Care,* as adopted by the American Academy of Pediatrics.
  - The most current version of the *Recommended Childhood Immunization Schedule/United States,* jointly adopted by the *American Academy of Pediatrics*, the *Advisory Committee on Immunization Practices,* and the *American Academy of Family Physicians,* unless determined otherwise by the *State Department of Health Services*.
  - The *Uniform Screening Panel* recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*, including breast cancer screening, annual cervical cancer screening, osteoporosis screening, and screening mammography. Benefits for preventive care visits include preconception and prenatal services.

  Covered Health Services also include voluntary family planning and all FDA-approved contraceptive drugs, devices, and other products for women as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law, including but not limited to the following services:

  - Office visits, examinations, patient education and counseling on contraception (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
  - Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
  - Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
  - Follow-up services related to all FDA-approved contraceptive drugs, devices, and other products (including all FDA-approved over-the-counter drugs, devices, and other products) for women. Follow-up services include, but are not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

- Voluntary female sterilization procedures, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure).

Benefits also include FDA-approved contraceptive drugs, devices, and products available over-the-counter when prescribed by a Network provider.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one hospital grade breast pump and double breast pump kit per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits for a hospital grade breast pump and double breast pump kit are provided taking into account the following determinations:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

- With respect to men, additional screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.
- Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Routine non-pediatric eye exam services for preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
- Hearing exams to determine the need for hearing correction, for all ages.
- Screening for obesity in all adults. Benefits include services that have in effect the current recommendations of the *United States Preventive Services Task Force* including intensive, multicomponent behavioral interventions for Covered Persons with a body mass index (BMI) of 30 kg/m2 or higher.

27. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose. Benefits include prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, health condition or congenital defect.
- Breast prosthesis, including custom-made prostheses when Medically Necessary, as required by the *Women's Health and Cancer Rights Act of 1998* and California regulation. Benefits include up to three mastectomy bras required to hold a prosthesis every 12 months. Benefits also include lymphedema stockings for the arm and adhesive skin support attachment for use with external breast prosthesis.
- Benefits for prosthetic devices to restore a method of speaking for a Covered Person incident to laryngectomy. This includes the initial and subsequent prosthetic devices, including installation accessories, as ordered by a Physician. Benefits include tracheo-esophageal voice prosthesis. Electronic voice producing machines are not covered.
- Benefits for diabetic shoes and inserts include off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification and follow-up care for podiatric devices; and repair or replacement of podiatric devices.
- Compression burn garments; lymphedema gradient compression stocking; light compression bandage; manual compression garment; and moderate compression bandage.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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

The prosthetic device must be prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license or is ordered by a licensed health care provider acting within the scope of his or her license.

Benefits are available for fitting, adjustment, repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Internally Implanted Devices: Covered Health Services include pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints, if they are implanted during a surgery that is a Covered Health Benefit under another benefit category under *Section 1: Covered Health Services*.

28. Reconstructive Procedures

Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- To improve function.
- To create a normal appearance, to the extent possible.

Reconstructive procedures include surgery or other procedures which are associated with a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Cosmetic Procedures are excluded from coverage.

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

29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Outpatient rehabilitation services (including habilitative services), limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.

- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

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

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits for habilitative services will be covered under the same terms and conditions applied to rehabilitative services under the Policy. Habilitative services include the outpatient rehabilitation services listed above. Benefits are provided for habilitative services provided for Covered Persons when the following condition is met:

- The initial or continued treatment must not be an Unproven Service or Experimental or Investigational. This condition does not apply to Medically Necessary occupational therapy or speech therapy for a Covered Person with a diagnosis of pervasive developmental disorder or Autism Spectrum Disorder.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Benefits for Habilitative Services are described under *Habilitative Services - Outpatient Therapy* and *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.*

30. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

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

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility (including inpatient services for habilitation services). Benefits are available for:

- Physician and nursing services.
- Room and board.
- Drugs prescribed by a Physician as part of your plan of care in the Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Skilled Nursing Facility by medical personnel.
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment.
- Imagine and laboratory services that Skilled Nursing Facilities ordinarily provide.
- Medical social services.
- Blood, blood products and their administration.
- Medical supplies.
- Physical, occupational and speech therapy.
- Respiratory therapy.

Please note that Benefits are available only if you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

Benefits will be available after our review of both the skilled nature of the service and the need for Physician-directed medical management. A service will not be "skilled" simply because there is not an available caregiver.

32. Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment. Benefits include Covered Health Services for inpatient detoxification as follows: hospitalization only for medical management of withdrawal symptoms, including room and board, physician services, Pharmaceutical Products, dependency recovery services, education, and counseling.

- Residential Treatment.
- All other outpatient items and services include Partial Hospitalization/Day Treatment, outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.
- Intensive Outpatient Treatment.
- Outpatient treatment. Benefits include Covered Health Services for outpatient treatment as follows: day-treatment programs, Intensive Outpatient Treatment programs, individual and group Substance Use Disorder counseling, medical treatment for withdrawal symptoms.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Prescription drugs.

Benefits for Covered Health Services provided on an outpatient basis are separated into the following two (2) categories in the *Schedule of Benefits* for the purpose of establishing the cost share that applies to the Benefit:

- *Outpatient Office Visits:*
  - Diagnostic evaluations and assessment, treatment planning, treatment and/or procedures, referral services, and medication management.
- *All Other Outpatient Treatment:*
  - 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.

The Mental Health/Substance Use Disorder Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

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

33. Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section also include vasectomy procedures, voluntary termination of pregnancy, and Medically Necessary termination of pregnancy. (Benefits for female sterilization methods are described under *Preventive Care Services*.)

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

Benefits under this section include:

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

34. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

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

Non-surgical treatment including clinical examinations, physical therapy, pharmacological therapy, oral appliances (orthotic splints), joint injections and trigger-point injections.

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

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

35. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.
- Dental evaluation, x-rays, fluoride treatment, and extractions as medically necessary to prepare the Covered Person's jaw for radiation therapy of cancer in the head or neck.
- Home hemodialysis and home peritoneal dialysis equipment and medical supplies. Benefits are limited to the standard item or equipment or supplies that adequately meets the Covered Person's medical needs.

36. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

Benefits for transplantation services are available to Covered Persons with human immunodeficiency virus (HIV) under the same terms and conditions available to Covered Persons without HIV.

37. Urgent Care Center Services

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

38. Virtual Visits

Virtual visits is distinct from Teleheatlh services since there no restrictions on where virtual visit services can originate. Virtual visits covers audio visual visits with a Physician from a designated network and accessible from any location not limited to home or office or *CMS* originating site. Unlike Telehealth Services, it requires audio visual medium to facilitate face-to-face interaction for an appropriate evaluation and diagnosis.

Virtual visits for Covered Health Services include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

39. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office. Benefits for routine vision examinations are limited to adults (age 19 and older). Benefits for routine vision examinations for Covered Persons under age 19 are provided as described in *Section 11: Pediatric Vision Care Services*.

Please note that Benefits are not available for charges connected to the purchase or fitting and dispensing of eyeglasses or contact lenses except for special contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye) when Medically Necessary.

Benefits for eye examinations required for the diagnosis and treatment of a health condition are provided under *Physician's Office Services*.

Additional Benefits Required By California Law

40. Breast Cancer Services

Benefits include diagnosis of, and treatment for, breast cancer. (Benefits for breast cancer screening are described under *Preventive Care Services*.)

41. Dental Anesthesia Services

Services including general anesthesia and associated Hospital or Alternate Facility charges when the clinical status or underlying medical condition of the Covered Person requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Alternate Facility setting. 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.

Services for the diagnosis or treatment of a dental disease are not Covered Health Services.

42. Enteral Formula and Amino Acid-Modified Food Products

Benefits for elementary dietary enteral formula when used as a primary therapy for Covered Persons with regional enteritis, enteral formula for Covered Persons who require tube feeding in accordance with Medicare guidelines are provided, and amino acid-modified food products used to treat congenital errors of amino acid metabolism. Benefits for enteral and parenteral nutrition include enteral formula and additives for adult and pediatric patients with inherited diseases of metabolism. Covered Health Services also include parenteral nutrition solutions. (Benefits for Formulas and Special Food Products for phenylketonuria (PKU) are described under *Phenylketonuria (PKU) Treatment*.)

43. Mastectomy Services

Coverage for mastectomies and lymph node dissections is provided in the same manner as other covered surgeries. The length of Hospital stay is determined by the attending Physician in consultation with the patient. We will not require the attending Physician to obtain prior approval of the length of the Hospital stay. The Policy covers all complications from a mastectomy including lymphedema. The Policy covers prosthetic devices and reconstructive surgery to restore and achieve symmetry for the patient, subject to the Policy's deductible and copayment requirements.

44. Nicotine Use Benefit

Benefits for Physician's services for the treatment of nicotine use and tobacco dependency. Benefits are available for all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for two 90-day treatment regimens when prescribed by a health care provider without prior authorization. (Benefits for counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions are described under *Preventive Care Services* in *Section 1: Covered Health Services*. Tobacco use and tobacco-related disease counseling and interventions include a minimum of eight counseling sessions of at least 10 minutes each.)

45. Off-Label Drug Use and Experimental or Investigational Services

Off-label drug use means that a Physician or provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than for which the FDA approved the drug. If a drug is

prescribed for off-label drug use, the drug and administration will be a Covered Health Service only if it satisfies the following criteria:

- The drug is approved by the FDA.
- The drug is prescribed by a Network Physician or provider for the treatment of a chronic and seriously debilitating or Life-Threatening condition.
- The drug is Medically Necessary to treat the medical condition.
- The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Benefits for Experimental or Investigational Services are limited to the following:

- Clinical trials for which Benefits are available as described under *Clinical Trials* above.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* above, and have a health condition that is likely to cause death within one year of the request for treatment, we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that health condition.

Nothing in this section shall prohibit us from use of a formulary, Copayments or Coinsurance, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the FDA. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

If Benefits are denied as an Experimental, Investigational or Unproven Service, the Covered Person may appeal the decision through independent external medical review as described under *Denial of Experimental, Investigational or Unproven Services* in *Section 6: Questions, Complaints and Appeals*. You may also call *Customer Care* at the telephone number on your ID card.

46. Orthotic Benefit

Benefits for orthotic devices, including original and replacement devices when devices are prescribed by a Physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license.

47. Osteoporosis Services

Services related to diagnosis, treatment, and appropriate management of osteoporosis. Services include, but are not limited to, all FDA-approved technologies and bone mass measurement. (Benefits for osteoporosis screening are described under *Preventive Care Services*.)

48. Phenylketonuria (PKU) Treatment

Benefits for the testing and treatment of phenylketonuria (PKU). (Benefits for PKU testing are described under *Preventive Care Services*.) Coverage includes Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specialized in the treatment of metabolic disease. The diet must be needed to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

"Formula" means an enteral product or enteral products for use at home that are prescribed by a Physician for the treatment of phenylketonuria (PKU).

"Special Food Product" means a food product that is both of the following:

- Prescribed by a Physician for the treatment of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
- Used in place of normal food products, such as grocery store foods, used by the general public.

49. Specialized Footwear

Special footwear needed as a result of foot disfigurement caused by any of the following:

- Cerebral palsy.
- Arthritis.
- Polio.
- Spina bifida.
- Diabetes.
- Accident.
- Developmental disability.

50. Telehealth Services

Benefits are available for Covered Health Services received through Telehealth. No in-person contact is required between a licensed health care provider and a Covered Person for Covered Health Services appropriately provided through Telehealth, subject to all terms and conditions of the Policy.

Prior to the delivery of Covered Health Services via Telehealth, the health care provider at the originating site shall verbally inform the Covered Person that Telehealth may be used and obtain verbal consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

We shall not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefits will not be excluded, limited or reduced solely due to conditions attributable to or exposure to diethylstilbestrol.

Benefit Limitations

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

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

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy. This exclusion does not apply to Covered Health Services provided for therapy services that are part of a physical therapy treatment plan for which Benefits are provided as described under *Home Health Care*, *Hospice Care*, *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment or Habilitative Services - Outpatient Therapy and Manipulative Treatment* in *Section 1: Covered Health Services*.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

   This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under *Dental Anesthesia Services* in *Section 1: Covered Health Services.*

   This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 10: Pediatric Dental Services.*

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

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

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

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

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums except as provided under *Dental Services - Accident Only* and *Preventive Care Services* in *Section 1: Covered Health Services* and *Section 10: Pediatric Dental Services* .

   Examples include:

   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*. This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 10: Pediatric Dental Services.*

4. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Services.* This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 10: Pediatric Dental Services.*

5. Treatment of congenitally missing, malpositioned or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under *Reconstructive Procedures* in *Section 1: Covered Health Services.* This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 10: Pediatric Dental Services.*

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Cranial banding.

3. The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Trusses.
    - Ultrasonic nebulizers.
4. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Services* and speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force* (*USPSTF*) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
2. Growth hormone therapy, except when Medically Necessary.
3. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product, except as Medically Necessary. Such determinations may be made up to six times during a calendar year.
4. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product unless Medically Necessary. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us or when Medically Necessary. Such determinations may be made up to six times during a calendar year.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for

cancer and for Experimental or Investigational Services and Unproven Services as defined under *Section 9: Defined Terms* and except that coverage which is provided for an *FDA*-approved drug prescribed for a use that is different from the use for which the *FDA* approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium,* or *Thomson Micromedex DrugDex;* or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the *FDA* or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

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

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under *Diabetes Treatment* and *Specialized Footwear* in *Section 1: Covered Health Services.*
5. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Services.*
6. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under *Diabetes Treatment* and *Specialized Footwear* in *Section 1: Covered Health Services*.
7. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under *Specialized Footwear* in *Section 1: Covered Health Services.*

G. Medical Supplies

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

   This exclusion does not apply to:
   - Lymphedema gradient compression stockings for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
   - Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under *Prosthetic Devices - Laryngectomy* in *Section 1: Covered Health Services.*

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Treatment* in *Section 1: Covered Health Services*.
- Ostomy and urological supplies for which Benefits are provided as described under *Ostomy and Urological Supplies* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified as mental disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Only Mental Health Services as treatments for R and T code conditions as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* chapters entitled "*Medication-Induced Movement Disorders and Other Adverse Effects of Medication"* and "*Other Conditions That May Be a Focus of Clinical Attention"* are excluded.
3. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate.*
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
5. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
6. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, that are all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Certificate under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Certificate under *Section 2: Exclusions and Limitations*.

I. Nutrition

1. Enteral feedings, even if the sole source of nutrition, except as described under *Enteral Formula and Amino Acid-Modified Food Products* and *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services.*
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods), except as described under *Enteral Formula and Amino Acid-Modified Food Products* and *Phenylketonuria (PKU) Treatment* in *Section 1: Covered Health Services.*

J. Personal Care, Comfort or Convenience

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

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to the surgical or non-surgical treatment of morbid obesity for which Benefits are provided as described under *Obesity Surgery* in *Section 1: Covered Health Services*. This exclusion does not apply to services that have in effect the current recommendations of the *United States Preventive Services Task Force* for obesity screening in children, adolescents and all adults as described under *Preventive Care Services* in *Section 1: Covered Health Services*.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Psychosurgery.
4. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
5. Biofeedback.
6. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS.
7. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in *Temporomandibular Joint (TMJ) Services* under *Section 1: Covered Health Services.* Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under *Other Health Education Services for You* in the section of the Certificate titled *Our Responsibilities*. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Services*.

9. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.

10. In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility.

M. Providers

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

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

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

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

   This exclusion does not apply to mammography.

N. Reproduction

1. The following infertility treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. The reversal of voluntary sterilization.

O. Services Provided under another Plan

1. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

P. Substance Use Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and* Limitations, the exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Educational services that are solely focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness and Serious Emotional Disturbances in *Section 9: Defined Terms* of the *Certificate.*
3. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, that are all of the following:
    - Medically Necessary.
    - Described as a Covered Health Service in this Certificate under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this Certificate under *Section 2: Exclusions and Limitations*.

Q. Transplants

1. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
2. Health services for transplants involving permanent mechanical or animal organs.

R. Travel

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

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. This exclusion does not apply to Medically Necessary pain management for acute and chronic pain provided during an Inpatient Stay in a Hospital.
2. Custodial Care or maintenance care. This exclusion does not apply to Custodial Care or maintenance care for which Benefits are provided under *Home Health Care*, *Hospice Care*, *Hospital - Inpatient Stay*, *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, Habilitative Services - Outpatient Therapy* and *Rehabilitative Services - Outpatient Therapy and Manipulative Treatment* in Section 1: *Covered Health Services*.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.

7. Services of personal care attendants. This exclusion does not apply to services for which Benefits are provided under *Hospice Care* and *Home Health Care* in *Section 1: Covered Health Services*.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to special contact lenses for aniridia and aphakia for which Benefits are provided as described under *Vision Examinations* in *Section 1: Covered Health Services*. This exclusion also does not apply to Vision Care Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 11: Pediatric Vision Care Services.*

2. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). This exclusion does not apply to contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye).

3. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

4. Bone anchored hearing aids except when the Covered Person has either of the following:

   - Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid; or
   - Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

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

U. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following:

   - Medically Necessary.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

2. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in the United States or non-war zones outside of the United States.

3. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

4. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

5. In the event a non-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance, any deductible or other dollar amount owed for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

6. Charges in excess of Eligible Expenses or in excess of any specified limitation.

7. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products.

8. Autopsy.

9. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law.

10. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

Who is Eligible for Coverage

All Eligible Persons and Dependents listed on the Enrolling Group's completed application form will be covered on the effective date of the Policy. Please see the definition of Eligible Person and Dependent in *Section 9: Defined Terms*.

Eligible Person

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

Eligible Persons must reside within the United States.

Dependent

Dependent generally refers to the Subscriber's Spouse, Domestic Partner or children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

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

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

All newborn Dependent children of the Subscriber are covered from the moment of birth. All newly adopted Dependent children of the Subscriber are covered from and after the moment the child is placed in the physical custody of the Subscriber for adoption. However, the Subscriber must complete an enrollment form for all newborn and all newly adopted Dependent children within 60 days of the event.

Coverage for other Dependents listed above begins on the date of the event if we receive the completed enrollment form and any required Premium within 60 days of the event that makes the other new Dependent eligible.

Coverage under the Policy will become effective no later than the first day of the first calendar month beginning after the date we receive the request for special enrollment.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated due to situations allowing for a rescission (fraud or intentional misrepresentation of a material fact), or because premiums were not paid on a timely basis

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

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

- Birth.
- Legal adoption.
- Placement for adoption.

- Marriage.
- Registering a Domestic Partner.

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan, including the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period or the Eligible Person or Dependent is employed by an employer that offers multiple health benefit plans and the person elected a different plan during Open Enrollment; and
- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including termination of employment, reduction in the number of hours of employment, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
    - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits benefits that do not constitute essential health benefits. Lifetime limits are prohibited on the dollar value of essential health benefits under a plan.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program* (the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program in California). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.
    - Loss of minimum essential coverage, including, but not limited to, loss of eligibility for coverage as a result of the following: legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, termination of employer contributions, and exhaustion of COBRA continuation coverage; loss of coverage because the covered employee becomes eligible for Medicare; and bankruptcy of the employer from whose employment the covered employee retired; loss of coverage due to an act or practice that constituted fraud, or an intentional misrepresentation of a material fact.
    - Gaining or becoming a dependent (due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship).
    - State or Federal Court mandate to be covered as a Dependent.
    - Release from incarceration.

- Health coverage issuer substantially violated a material provision of the health coverage contract.
- Gaining access to new health benefit plans as a result of a permanent move.
- Receiving services from a contracting provider under another health insurance plan for (a) an acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration), (b) a serious chronic condition(a medical condition due to a disease, illness, 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), (c) a pregnancy, (d) a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less), (e) care of a newborn child between birth and age 36 months, or (f) performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured, and that provider is no longer participating in the health benefit plan.
- Being misinformed that one had minimum essential coverage.
- Returning from active duty of the reserve forces of the United States military or the California National Guard.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 60 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

When the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

If UnitedHealthcare Insurance Company can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may rescind your coverage, with written notice of your right to appeal. No Policy will be rescinded after 24 months following the issuance of the Policy. If we rescind your coverage, we will send the Employer Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Insurance. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare Insurance Company may cancel your coverage, as permitted by law. Should your coverage be rescinded due to fraud, or an intentional misrepresentation of a material fact, we may take any and all actions allowed by law, which may include demanding that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TDD 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Coverage for a Disabled Dependent Child

Initial Enrollment of a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached 26 years old. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of a physically or mentally disabling illness or health condition.
- Depends chiefly on the Subscriber for support.

We will notify the Subscriber that the Enrolled Dependent child's coverage will end upon attainment of the limiting age unless the Subscriber submits proof of the criteria described above to us within 60 days of the date of receipt of our notification. We will send this notification to the Subscriber at least 90 days prior to the date the Enrolled Dependent child attains the limiting age. Upon receipt of the request of the Subscriber for continued coverage of the child and proof of the criteria described above, we will determine whether the Enrolled Dependent child meets the criteria before the child attains the limiting age. If we fail to make the determination by that date, coverage of the Enrolled Dependent child will continue pending our determination.

We may continue to ask you for proof that the child continues to be disabled and dependent. However, we will not ask for this information more than once a year after a two-year period following the child's attainment of the limiting age.

If the Subscriber or Covered Person changes carriers to another insurer or to a health care service plan ("plan"), the new insurer or plan will continue to provide coverage for the Dependent child. The new

insurer or plan may request information about the Dependent child initially and not more frequently than annually thereafter to determine if the Dependent child continues to satisfy the following criteria:

- Is not able to be self-supporting because of a physically or mentally disabling illness or health condition.
- Depends chiefly on the Subscriber for support.

The Subscriber or Covered Person must submit the information requested by the new insurer or plan within 60 days of receiving the request.

Continued Enrollment of a Disabled Child

A disabled Dependent child who is age 26 or older will be continued to be enrolled under the Policy if he or she is enrolled at the time he or she attains age 26, provided that satisfactory evidence of such disability is provided to us during the period commencing 60 days before and ending 60 days after the Dependent child's 26th birthday.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy was terminated.

Continuation of Coverage

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

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

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

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

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

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage - Applicable to Enrolling Groups with 20 or more Eligible Employees

A Qualified Beneficiary is an individual who was covered under the Policy and has also exhausted their continuation coverage under Federal law (COBRA) for which they were entitled to less than 36 months of coverage. Extended continuation coverage under state law (Cal-COBRA) may be obtained for up to 36 months from the date that the COBRA continuation began.

Qualifying Events for Continuation Coverage under State Law (Cal-COBRA)

The date of your "Qualifying Event" is the date that continuation coverage began under your federal COBRA continuation.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal-COBRA)

Notification of any right to extended coverage under Cal-COBRA will be provided to you by us within 90 days prior to your termination under COBRA. Continuation must be elected within 30 days of when COBRA continuation is scheduled to end.

The Enrolling Group or the Enrolling Group's designated plan administrator will notify you of any annual Benefit or Premium changes that may occur during your Open Enrollment Period.

Termination Events for Continuation Coverage under State Law (Cal-COBRA)

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

- Thirty-six months from the date of your qualifying event.
- The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare.
- The date, after electing continuation coverage that the Qualified Beneficiary has other hospital, medical or surgical coverage, or is or becomes covered under another group health plan.
- The date the Qualified Beneficiary is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act.
- The date coverage terminated under the Policy for failure to make timely payment of the Premium.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading Events Ending Your Coverage.

Continuation Coverage under State Law (Cal-COBRA) - Applicable to Enrolling Groups with 1-19 Eligible Employees

You should call your Enrolling Group or us if you have questions about your right to continue coverage under state law.

In order to be eligible for continuation coverage under state law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any individual who was covered under the Policy on the day before a qualifying event.

Qualifying Events for Continuation Coverage under State Law (Cal-COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage.

A. Termination of employment or reduction in hours of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct; or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. For Enrolled Dependents only, the entitlement of the Subscriber to Medicare benefits.

The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

Exemptions to Coverage under State Law (Cal-COBRA)

The continuation requirements of this section do not apply to the following:

- Individuals who are or who become entitled to Medicare benefits.
- Individuals who have other hospital, surgical or medical coverage, or who are or become covered under another group health plan.
- Individuals who are covered, become covered, or are eligible for federal COBRA coverage.
- Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Code.
- Qualified Beneficiaries who fail to meet the requirements of this section regarding notification of a qualifying event or election of continuation coverage.
- Qualified Beneficiaries who fail to submit correct Premium for continuation coverage.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal-COBRA)

The Subscriber or other Qualified Beneficiary must notify us within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent, including loss of eligibility of an Enrolled Dependent due to the Subscriber's entitlement to Medicare. If the Subscriber or other Qualified Beneficiary fails to notify us of these events within the 60 day period, we are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under state law, the Subscriber must notify us within 30 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from us. The Qualified Beneficiary's request must be in writing and delivered to us by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company within the 60-day period following the later of: (1) the date that the insured's coverage under the group health plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice of the ability to continue coverage under the group health benefit plan.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to us must be paid on or before the 45th day after electing continuation. The amount of the initial Premium must be equal to the full amount billed by us. Failure to submit the correct initial Premium amount billed within the 45-day period will disqualify the Qualified Beneficiary from receiving continuation coverage pursuant to this section.

If you were covered under a prior carrier and your former employer replaces your prior coverage with us, you may continue the remaining balance of your unused coverage with us, but only if you enroll with us and pay the required Premium to us within 30 days of receiving notice of the termination from the prior carrier.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Terminating Events for Continuation Coverage under State Law (Cal-COBRA)

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

- Thirty-six months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because of the Subscriber's termination of employment or reduction in hours. (i.e., qualifying event A).
    - If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A., then the Qualified Beneficiary must provide notice of such disability to us within 60 days of the date of the determination letter and prior to the end of the original 36 month continuation coverage period. If the Qualified Beneficiary is no longer disabled, then coverage will be terminated

the later of the original 36 month continuation coverage period, or the month that begins more than 31 days after the date of the final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination.

- The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, or loss of eligibility due to the Subscriber's entitlement to Medicare benefits (i.e. qualifying events B, C, D, or E).
- The date, after electing continuation coverage, that the Qualified Beneficiary has other hospital, medical, or surgical coverage, or is or becomes covered under another group health plan.
- The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading *Events Ending Your Coverage.*

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us.

Notice of Claim: Written notice of claim must be furnished to us within 20 days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

Proof of Loss: Written proof of loss must be furnished to us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give poof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms: Upon receipt of a written notice of a claim, we will provide you with claim forms for filing proof of loss. If we do not provide claim forms to you within 15 days after we receive written notice of a claim from you, you will have deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the timeframe for fling a proof of loss (as described above), written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

As a third alternative, you may provide us with the following specific information in lieu of the claim form:

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

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

Attn: Claims Department

P.O. Box 29077

Hot Springs, AR 71903

Time of Payment of Claim: Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid (to the Subscriber) as they accrue and any balance remaining unpaid at termination of the period of liability will be paid (to the Subscriber) immediately upon receipt of due written proof.

Payment of Claims to the Subscriber:

Subject to any written direction of the Subscriber in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at our option, and unless the Subscriber requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

We will reimburse claims or any portion of any claim, whether in-state or out-of-state, for Covered Health Services, as soon as possible, no later than 30 working days after receipt of the claim.

However, a claim or portion of a claim may be contested or denied by us. In that case you will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including, for each reason, the factual and legal basis known at the time by us for contesting or denying the claim. If the reason is based solely on facts or solely on law, we will provide only the factual or the legal basis for contesting or denying the claim. We will provide a copy of such notice to each Covered Person who received services pursuant to the claim that was contested or denied and the health care provider that provided the services at issue.

If an uncontested claim is not reimbursed by delivery to your address of record within 30 working days after receipt, we will pay interest at the rate of 10% per annum beginning with the first calendar day after the 30-working-day period.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Section 6: Questions, Complaints and Appeals

IMPORTANT NOTICE - CLAIM DISPUTES

Should a dispute concerning a claim arise, contact us first. If the dispute is not resolved contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the California Department of Insurance at:

- 1-800-927 HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

A Covered Person may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

For further information about complaint procedures please read the section below.

IMPORTANT NOTICE - 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 the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides 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

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

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

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

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

What to Do if You Disagree with Our Adverse Benefit Determination

If you disagree with our Adverse Benefit Determination, you may file a formal appeal. Our internal review appeals procedures are designed to deliver a timely response and resolution to your appeal. We will continue to provide coverage for the Covered Health Service under review until the Adverse Benefit Determination is resolved.

An Adverse Benefit Determination is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Service or not Medically Necessary or appropriate. An adverse benefit determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution

process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

Appeals Determinations

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

For procedures associated with Urgent Requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

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

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. (For procedures associated non-Urgent Requests for Benefits based on Medical Necessity for Benefits, see *Non-Urgent Pre-Service Requests Based on Medical Necessity* below.)
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days of the receipt of information that is reasonably necessary to make this determination. The determination will be communicated to the provider in a manner that is consistent with current law.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Non-Urgent Pre-Service Requests Based on Medical Necessity

Decisions to deny or modify requests for authorization of Covered Health Services for a Covered Person, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals. The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of Covered Health Services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Covered Person's condition, not to exceed five business days from our receipt of the information reasonably necessary and requested to make the decision.
- If the Covered Person's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Covered Person's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Covered Person's condition, but not later than 72 hours after our receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because: (1) we are not in receipt of all of the information reasonably necessary and requested or (2) consultation by an expert reviewer is required, or (3) the reviewer has asked that an additional examination or test be performed upon the Covered Person, provided the examination or test is reasonable and consistent with good medical practice, the reviewer will notify the Physician and the Covered Person, in writing, upon the earlier of the expiration of the required time frame above or as soon as we become aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and

requested by us, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be decided within 5 business days of the request.

We will provide continued coverage pending the outcome of an appeal. We will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

Denial of Experimental, Investigational or Unproven Services

If we deny Benefits for a medical procedure or plan of treatment as being Experimental or Investigational Services or Unproven Services and those services are for a Covered Person Life-Threatening or seriously debilitating condition, we will provide you with written notification of all of the following:

- Written notice within 5 business days describing how you can request an external review of any decision that denies Experimental or Investigational Services or Unproven Services.
- The specific medical and scientific reasons for the denial and specific references to pertinent Policy provisions upon which the denial is based.
- A description of the alternative medical procedures or treatments covered by the Policy, if any.
- A description of the process of external review explaining how you or your representative can appeal the denial and participate in the review. An external review will be provided to the Covered Person within 30 calendar days following the receipt of a request for external review. An expedited review may be held within 5 business days at the request of the treating Physician.

For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Medically Necessary or was an Experimental, Investigational or Unproven Service, you may request an Independent Medical Review (IMR) from the California Department of Insurance (CDI) at no cost to you. However, you must first file an appeal of the denial with us.

First Steps: Appeal the denial using our internal appeals/grievance process.

- Find out the reason for the denial and review the Policy language supporting the denial.
- Submit all necessary support for treatment, with doctor(s) statements and medical records.
- Provide research showing the treatment requested is accepted and appropriate, if possible.

IMR Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IMR request with the California Department of Insurance. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent Medical Review: In this process, expert independent medical professional review the medical decisions made by us and often decide in favor of the Covered Person getting the medical treatment requested.

An IMR can be requested if our decision involves:

- Health claims that have been denied, modified, or delayed by us because a Covered Health Service or treatment was not considered Medically Necessary;
- Health claims that have been denied for urgent or emergency services that a provider recommended was Medically Necessary;
- Health claims that have been denied as being Experimental, Investigational or Unproven Services

The results of an external review requested for Experimental, Investigational or Unproven Services can be rendered in seven days if you suffer from a terminal illness and your Physician requests an expedited review.

6 Easy Steps to IMR:

1. Notify CDI to request an IMR and fill out an application.

2. Agree and provide written consent to participate in IMR.

3. The CDI determines if the request is eligible for IMR.

4. The IMR Organization will have 30 days to review once all information is gathered--unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.

5. The IMR organization will send the decision to the Covered Person, UnitedHealthcare Insurance Company, and the California Insurance Commissioner.

6. The California Insurance Commissioner will adopt the recommendation of the IMR organization and promptly notify the Covered Person and us. The decision is binding on UnitedHealthcare Insurance Company.

Reviewing Coverage Denials: If we deny treatment as not a Covered Health Service, or if CDI finds that the issue does not involve a disputed health care service, CDI will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Insurance:

You may contact the California Department of Insurance for information on the independent external review program by calling:

- 1-800-927 HELP (1-800-927-4357) if the Covered Person resides in the State of California.
- 213-897-8921 if the Covered Person resides outside of the State of California.

You may also write the California Department of Insurance at:

California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is based on California regulations.

When Coordination of Benefits Applies

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

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

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

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

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; medical benefits under group or individual automobile contracts; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

   The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

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

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

considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

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

When Medicare is Secondary

If you have other health insurance which is primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We offer health care coverage to Eligible Persons with a physical handicap under the same terms and conditions as are offered to Eligible Persons without a physical handicap. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. Your right to Benefits is limited to the Covered Health Services described in *Section 1: Covered Health Services*. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service under the Policy, you will be responsible for paying all charges and no Benefits will be paid.

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

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

Our Relationship with Providers and Enrolling Groups

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

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

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

The Enrolling Group is solely responsible for all of the following:

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

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

questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount that is a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

Notice

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

We will provide notice to the Enrolling Group and all affected Subscribers if either of the following occurs:

- **For discontinuance of a particular health benefit plan.** Your coverage may be terminated if UnitedHealthcare decides to cease offering the a particular health benefit plan upon 90 days written notice to the California Department of Insurance, the Enrolling Group and all affected Subscribers covered under the health benefit plan. When a health benefit plan is discontinued, UnitedHealthcare will make all other health benefit plans offered to new group business available to the Enrolling Group without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.
- **For discontinuance of all new and existing health benefit plans.** Your coverage may be terminated if UnitedHealthcare decides to cease offering existing or new plans in the group market in the State of California upon 180 days written notice to the California Department of Insurance, the Enrolling Group and all affected Subscribers covered under the health benefit plans.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Enrolling Group to void the Policy, including fraud or an intentional misrepresentation of a material fact, after twenty-four (24) months from the date of issuance of the Policy.

Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Interpretation of Benefits

We will do the following:

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

Other persons or entities may provide services in regard to the administration of the Policy.

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

Administrative Services

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

Amendments to the Policy

To the extent permitted by law, we reserve the right to change, modify, withdraw or add Benefits or terminate the Policy.

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

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

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

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

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

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

Examination of Covered Persons

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

Physical Examinations and Autopsy: We, at our own expense, shall have the right and opportunity to examine the Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Workers' Compensation not Affected

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

Reimbursement – Right to Recovery

In consideration of the coverage provided by this Certificate of Coverage, we shall have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.

- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.
- These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our right to reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim,
  - responding to requests for information about any accident or injuries, and
  - making court appearances, we will not require you to travel more than 60 miles from home for a court appearance without reimbursing your reasonable expenses.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced. Benefits are considered benefits advanced where it is either now known or later known that some other party may be the primary payor. Benefits advanced will be expected to be repaid through either coordination and/or reimbursement.
- You agree to advise us, in writing, within a reasonable time of your claim against the third party and to take such action, provide such information and assistance, and execute such documents as we may reasonably require to facilitate enforcement of the claim. We may have a right to a lien, to the extent of benefits advanced, upon any recovery that you receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise.
- That the provisions of this section will apply to your survival claim, estate, and/or the personal representative of your estate.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Change of Beneficiary

The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to change of beneficiary or beneficiaries, or to any other changes in this Policy. Please refer to *Section 3: When Coverage Begins* for information on who is eligible for coverage under the Policy.

Non-Discrimination in Contract Availability or Terms

No admitted insurer, licensed to issue disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefore, or issue or cancel that insurance, under conditions less favorable to the Eligible Person than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, sex, gender, gender identity, gender expression, national origin, ancestry or sexual orientation.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof is required to be furnished.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Eligible Person whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

Section 9: Defined Terms

Adverse Benefit Determination - Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Service or not Medically Necessary or appropriate. An adverse benefit determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time).

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

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

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

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

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. 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. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies. An Annual Deductible will not apply to Network Benefits for preventive care.

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

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Health Treatment - professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with pervasive developmental disorder or Autism Spectrum Disorders, and that meet all of the following criteria:

- The treatment is prescribed by a Physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to

Chapter 6.6 (commencing with Section 2900) of, Division 2 of the California Business and Professions Code.

- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
  - A qualified autism service provider.
  - A qualified autism service professional supervised and employed by the qualified autism service provider.
  - A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific Covered Person being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
  - Describes the Covered Person's behavioral health impairments to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Covered Person's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or Autism Spectrum Disorders.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

In applying the above definition, "qualified autism service provider," qualified autism service professional," and "qualified autism service paraprofessional" shall have the following meanings:

- "Qualified autism service provider" means either of the following:
  - A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
  - A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or Autism Spectrum Disorders, provided the services are within the experience and competence of the licensee.
- "Qualified autism service professional" means an individual who meets all of the following criteria:
  - Provides Behavioral Health Treatment.
  - Is employed and supervised by a qualified autism service provider.
  - Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- Has training and experience in providing services for pervasive developmental disorder or Autism Spectrum Disorders pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.

- "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - Is employed and supervised by a qualified autism service provider.
  - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
  - Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
  - Has adequate education, training, and experience, as certified by a qualified autism service provider.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Chronic and Seriously Debilitating - diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

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

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

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which are all of the following:

- Medically Necessary.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be

skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal Spouse or a child of the Subscriber or the Subscriber's Spouse. All references to the Spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. The term child includes any of the following:

- A natural child.
- A stepchild.
- An adopted child.
- A child placed for adoption.
- Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes a dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

Enrollment may not be denied based on any of the following facts:

- The child does not reside with the Subscriber.
- The child is born out of wedlock.
- The child is not claimed as a dependent on the Subscriber's federal or state income tax.
- The child lives outside the service area.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

If the Subscriber is required by a court or administrative order to provide health coverage for the Subscriber's child, the child will be able to be enrolled regardless of any enrollment season restriction. We will enroll the child upon application for enrollment by the custodial parent, the non-custodial parent, the Medi-Cal program, or the local child support agency.

We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Enrolling Group receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Enrolling Group receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this Policy.
- The Enrolling Group has eliminated dependent health coverage for all its Subscribers.
- The Subscriber is no longer eligible for coverage.

We will notify both parents and any other person having custody of a child in writing at any time that health insurance for the child is terminated.

When a child is enrolled in a plan of the non-custodial parent or a parent sharing custody or temporary control of the child, we will:

- Provide the custodial parent with any information necessary to obtain Benefits and services for the child under this Policy.
- Allow the custodial parent or the health care provider with the custodial parent's approval, to submit claims for Benefits, without the approval of the non-custodial parent.
- Make claim payments directly to the person or entity who submitted the claim, that is, the custodial parent, the health care provider, or the Medi-Cal program.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.

Domestic Partner - a person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
  - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
  - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

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

- Can withstand repeated use.

- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a health condition or their symptoms.
- Is generally not useful to a person in the absence of a health condition or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Covered Person to result in any of the following:

- placing the Covered Person's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
  - there is inadequate time to effect safe transfer to another Hospital prior to delivery, or
  - a transfer poses a threat to the health and safety of the Covered Person or unborn child.

An Emergency also includes a psychiatric emergency medical condition which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Covered Person as being either of the following:

- An immediate danger to himself or herself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies,

treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Life-Threatening or seriously debilitating condition, we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that health condition.
- Benefits are available for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex*; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- 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 visits).
- Up to 100 visits per calendar year (counting all home health care visits).

Note: If a visit by a nurse, medical social worker, or physical, occupational or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health care aide lasts longer than four hours, then each additional increment of four hours counts a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Covered Health Services counts toward these visit limits. For example, if a home health care aide and a nurse are both at your home during the same two hours, that counts as two visits.

Life-Threatening - means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary (Medical Necessity) - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a health condition, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following:

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from

time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - Mental Illness is defined as those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded in *Section 2: Exclusions and Limitations*.

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

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

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount that you will pay per year which includes the Annual Deductible, Copayments, or 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. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any acupuncturist, audiologist, certified respiratory care practitioner, chiropractor, clinical social worker, dentist, dietitian, dispensing optician, marriage, family and child counselor, mental health clinical nurse specialist, nurse midwife, nurse practitioner, obstetrician/gynecologist, occupational therapist, optometrist, pharmacist, physical therapist, podiatrist, psychologist, psychiatric-mental health nurse, respiratory care practitioner, speech-language pathologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

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

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

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

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

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Serious Emotional Disturbances - when a Enrolled Dependent child who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the disorder, one or more of the following is true:

- The child is at risk of removal from home or has been ill for more than six months.
- The child displays psychotic features, risk of suicide or risk of violence.
- The child meets special education eligibility requirements under state law.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Severe Mental Illness - any of the following diagnosed Severe Mental Illnesses: schizophrenia or schizoaffective disorder, bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or Autism Spectrum Disorders; anorexia nervosa; and bulimia nervosa.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

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

Spouse - a person who is married to an Employee. All references to Spouse shall include a Domestic Partner. Please refer to the definition of *Domestic Partner*.

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

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and*

Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded.

Telehealth - means the mode of delivering Covered Health Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

In applying the above definition, "asynchronous store and forward," "distant site," "originating site," and "synchronous interaction" shall have the following meanings:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient.
- "Distant site" means a site where a licensed health care provider who provides Covered Health Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Covered Health Services are provided via a telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a licensed health care provider located at a distant site.

Total Disability or Totally Disabled - A disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Triage - Triage is the assessment of a Covered Person's health concerns and symptoms via communication, with a Physician, registered nurse, or other qualified health professional acting within his or her scope of practice and 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 care. Triage or screening services are available 24 hours per day, 7 days per week.

Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

- If you have a Life-Threatening or seriously debilitating condition, we may consider an otherwise Unproven Service to be a Covered Health Service for that health condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that health condition.
- We may consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a health condition that is not a Life-Threatening or seriously debilitating condition. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
    - The service must be available from a Network Physician and/or a Network facility.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen health condition, or the onset of acute or severe symptoms.

Urgent Request - any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the Covered Person or the ability of the Covered person to regain maximum function, or
- In the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the claimant to serve pain that cannot be adequately managed without the care or treatment that is the subject of the claim for medical care or treatment.

In determining whether a claim for medical care or treatment involves urgent care, the individual acting on behalf of the plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Covered Person's medical condition determines that a claim involves urgent care, the claim for medical care or treatment will be treated as an urgent care claim.

Section 10: Pediatric Dental Services

This section describes Benefits for Pediatric Dental Services for which Benefits are available for Covered Persons under the age of 19. Please refer to the attached *Pediatric Dental Services Schedule of Benefits* for details about:

- The amount you must pay for these Benefits for Pediatric Dental Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Benefits for Pediatric Dental.
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Benefits terminate on the last day of the month the Covered Person reaches the age of 19.

Benefits for Pediatric Dental Services

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

A. Necessary for dental health and consistent with professionally recognized standards of practice.

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

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

D. Not excluded as described below under *Pediatric Dental Exclusions and Limitations*.

Network Benefits:

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

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

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in this *Certificate* if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider or a Dental Provider in the event of an emergency or urgent care.

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 *Certificate*.

Diagnostic and Preventive Benefits

Benefits include:

- Initial and periodic oral examinations.
- Consultations, including specialist consultations.

- Topical fluoride treatment.
- Preventive dental education and oral hygiene instruction.
- Roentgenology (x-rays).
- Prophylaxis services (cleanings).
- Dental sealant treatments.
- Space maintainers, including removable acrylic and fixed band type.

Restorative Benefits

Benefits for restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries.
- Micro filled resin restorations which are non-cosmetic.
- Replacement of restoration.
- Use of pins and pin build-up in conjunction with a restoration.
- Sedative base and sedative fillings.

Oral Surgery Benefits

Benefits for oral surgery include:

- Extractions, including surgical extractions.
- Removal of impacted teeth.
- Biopsy of oral tissues.
- Alveolectomies.
- Excision of cysts and neoplasms.
- Treatment of palatal torus.
- Treatment of mandibular torus.
- Frenectomy.
- Incision and drainage of abscesses.
- Post-operative services, including exams, suture removal and treatment of complications.
- Root recovery (separate procedure).
- General anesthesia or intravenous/conscious sedation.

Endodontic Benefits

Benefits for endodontics include:

- Direct pulp capping.
- Pulpotomy and vital pulpotomy.
- Apexification filling with calcium hydroxide.
- Root amputation.
- Root canal therapy, including culture canal limited retreatment of previous root canal therapy as specified below.

- Apicoectomy
- Vitality tests.

Periodontics Benefits

Benefits for periodontics include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis.
- Periodontal scaling and root planing, and subgingival curettage.
- Gingivectomy.
- Osseous or muco-gingival surgery.

Crown and Fixed Bridge Benefits

Benefits for crown and fixed bridge include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel.
- Related dowel pins and pin build-up.
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold.
- Recementation of crowns, bridges, inlays and onlays.
- Cast post and core, including cast retention under crowns.
- Repair or replacement of crowns, abutments or pontics.

Removable Prosthetics Benefits

Benefits for removable prosthetics include:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers.
- Office or laboratory relines or rebases.
- Denture repair.
- Denture adjustment.
- Tissue conditioning.
- Denture duplication.
- Space maintainer.
- Stayplate.

Medically Necessary Orthodontic Services

Benefits for orthodontics when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. Medically necessary orthodontic services means orthodontic treatment needed to ensure normal chewing and speaking, as well as to treat cleft palate and severe malocclusion (the misalignment of teeth between upper and lower teeth). Benefits include services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. All orthodontic treatment should be prior authorized.

Other Benefits:

Other Covered Dental Services include:

- Local anesthetics.
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.
- Emergency treatment
- Palliative treatment.

Pediatric Dental Exclusions and Limitations

Except as may be specifically provided in this *Certificate* under *Benefits for Covered Dental Services*, Benefits are not provided under this *Certificate* for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this *Certificate* under *Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is Experimental or Investigational or Unproven in the treatment of that particular condition. Denials of coverage are subject to Independent Medical Review for Experimental and Investigational Therapies.
7. Dispensing of drugs/medications not normally supplied in a dental office.
8. Replacement of loss or theft of dentures or bridgework.
9. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this *Certificate*.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
12. Dental implants are excluded, but it is considered optional dental treatment. An optional benefit is a dental benefit that you choose to have upgraded. For example when a filling would correct the tooth but you choose to have a full crown instead. If you choose to have an implant rather than a Covered Dental Service such as a denture or fixed bridge, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a dental implant.
13. Orthodontic treatment unless medically necessary as described under *Medically Necessary Orthodontic Services* above.
14. Surgical removal of impacted teeth is Covered Dental Service only when evidence of pathology exists.
15. Benefits for crowns are limited as follows:

- Crowns will only be covered if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Limited to five (5) units of crown per arch. Upon the sixth unit, treatment is a full mouth reconstruction. If you choose to have a full mouth reconstruction, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a full mouth reconstruction.

16. Benefits for fixed bridge are limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment. An optional benefit is a dental benefit that you choose to have upgraded. If a fixed bridge is chosen, the covered benefit will be for a partial bridge.
- A fixed bridge is covered when it is Necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. An optional benefit is a dental benefit that you choose to have upgraded.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch. An optional benefit is a dental benefit that you choose to have upgraded.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactorily by repair.
- If an optional benefit is chosen by the Covered Person, we will pay our cost share of the Covered Dental Service and the Covered Person will be responsible for the additional cost of the upgrade.
- Limited to five (5) units bridgework per arch. Upon the sixth unit, treatment is a full mouth reconstruction. If you choose to have a full mouth reconstruction, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a full mouth reconstruction.

17. Benefits for removable prosthetics are limited as follows:

- Partial dentures will not be replaced within 36 months unless:
  - It is Necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
  - The denture is unsatisfactory and cannot be made satisfactory.
- Covered Dental Services for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the Covered Person and the Dental Provider, and is not Necessary to satisfactorily restore an arch, the Covered Person will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of dental arch.
- Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- Covered Dental Services for complete dentures will be limited to the Benefit level for a standard procedure. If more personalized or specialized treatment is chose by the Covered

Person and the Dental Provider, the Covered Person will be responsible for all additional charges.

- Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture.
- Stayplates are a Covered Dental Service only when used as anterior space maintainers for children.

Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Proof of Loss: Written proof of loss must be furnished to us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give poof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms: Upon receipt of a written notice of a claim, we will provide you with claim forms for filing proof of loss. If we do not provide claim forms to you within 15 days after we receive written notice of a claim from you, you will have deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the timeframe for fling a proof of loss (as described above), written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

In lieu of a claim form, you may provide us with the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Time of Payment of Claim: Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid (to the Subscriber) as they accrue and any balance remaining

unpaid at termination of the period of liability will be paid (to the Subscriber) immediately upon receipt of due written proof.

Payment of Claims to the Subscriber:

Subject to any written direction of the Subscriber in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at our option, and unless the Subscriber requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of this *Certificate*:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this *Certificate*.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

Necessary - Dental Services and supplies under this *Certificate* which are determined through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.
        - Provided in a clinically controlled research setting.

- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Certificate*. The definition of Necessary used in this *Certificate* relates only to Benefits under this *Certificate* and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual and Customary - Usual and Customary fees are calculated based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association*)
- As reported by generally recognized professionals or publication.
- As utilized for Medicare.

As determined by medical or dental staff and outside medical or dental consultants.

Section 11: Pediatric Vision Care Services

This section describes Benefits for Pediatric Vision Care Services which Benefits are available for Covered Persons under the age of 19. Please refer to the attached *Pediatric Vision Care Services Schedule of Benefits* for details about:

- The amount you must pay for these Benefits for Pediatric Vision Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Benefits for Pediatric Vision Care Services.
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Benefits terminate on the last day of the month the Covered Person reaches the age of 19.

Routine Opthalmologic Exam with Refraction

A routine opthalmologic examination of the condition of the eyes, principal vision functions and refraction according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.
- Dilation, if professionally indicated.

Post examination procedures will be performed only when materials are required.

Low Vision Service

Low vision is a significant loss of vision but not total blindness. Opthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and

instruction to maximize the remaining usable vision for Covered Persons with low vision. Covered low vision services will include a comprehensive low vision evaluation, low vision follow-up care and low vision items such as high-power spectacles, magnifiers and telescopes.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses or contact lenses. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lenses include a choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Lens Extras

Eyeglass Lenses. The following lens extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses or contact lenses. Eyeglasses consist of either eyeglass lenses or both eyeglass lenses and frames. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contacts and follow-up care.

You are eligible to select only one of either eyeglasses or contact lenses. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.

- Aniridia.
- Post-traumatic disorders.

Other Vision Services

- Ultraviolet protective coating.
- Polycarbonate lenses.
- Blended segment lenses.
- Intermediate vision lenses.
- Standard progressives.
- Premium progressives (Varilux, etc.)
- Photochromatic glass lenses.
- Plastic photosensitive lenses (transitions).
- Polarized lenses.
- Standard anti-reflective (AR) coating.
- Premium AR coating
- Ultra AR coating.
- Hi-index lenses.
- Select progressive lenses.
- Ultra progressive lenses.

Pediatric Vision Exclusions

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

1. Non-prescription items (e.g. Plano lenses).
2. Replacement or repair of lenses and/or frames that have been lost or stolen.
3. Lens Extras not listed in under *Benefits for Vision Care Services.*
4. Missed appointment charges.
5. Applicable sales tax charged on Vision Care Services.

Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information. Upon your request, we will provide a claim form to you within 15 days of your request. If you do not request such a claim form, you may submit the required information below.

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

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of this *Certificate*:

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

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

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

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

Section 12: Outpatient Prescription Drug Services

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

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

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

The tiers for Outpatient Prescription Drugs are defined as follows, per California state regulation:

Tier 1 consists of most Generic drugs and low-cost preferred Brand-name drugs.

Tier 2 consists of non-preferred Generic drugs, preferred Brand-name drugs and any other drugs recommended by our pharmacy and therapeutics committee based no safety, efficacy, and cost.

Tier 3 consists of non-preferred Brand-name drug or drugs that are recommended by our pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 consists of drugs that are biologics, drugs that the FDA or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the insured to have special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than six hundred dollars ($600) net of rebates for a one-month supply.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please 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.

Identification Card (ID Card) - Network Pharmacy

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

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

You may seek reimbursement from us as described in this *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the

Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Submit your claim to:

Optum Rx

Attn: Claims Department

P.O. Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid.

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

Smart Fill Program - Split Fill
Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Smart Fill Program - 90 Day Supply
Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Limitation on Selection of Pharmacies

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

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-

prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

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

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. Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

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 diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills).
- Disposable needles and syringes needed for injecting Prescription Drug Products.
- Inhaler spacers need to inhale Prescription Drug Products. Benefits also include inhaler spacers when medically necessary for the management and treatment of pediatric asthma.
- Benefits for Prescription Drug Products are available for appropriately prescribed pain management for terminally ill patients when Medically Necessary.
    - **Prior Authorization for cases involving Prescription Drug Products for Urgent Requests of appropriately prescribed pain management medications for terminally ill patients:** We will notify the Covered Person the Benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt request, unless we do not receive sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Policy. In the case of such a failure, we will notify the Covered Person as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete the prior authorization request. The Covered Person will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. We will notify the Covered Person of the Benefit determination as soon as possible, but in no case later than 48 hours after the earlier of our receipt of the specified information, or the end of the period given to the Covered Person to provide the specified additional information.
- Prescription Drug Products that have received FDA-approval for marketing for one or more uses and prescribed for an off-label use are Covered Health Services as described under *Experimental or Investigational Services* in *Section 1: Covered Health Services*. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

Please see *Defined Terms for Outpatient Prescription Drug Services* in this section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

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

Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in this *Certificate*, *Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

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

Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

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.

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. 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.

Exclusions

Exclusions from coverage listed in the *Certificate* apply also to these services. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay. (Benefits for Prescription Drug Products provided during an Inpatient Stay are available as described under *Hospital - Inpatient Stay* in *Section 1: Covered Health Services*.)
4. Experimental or Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Any product dispensed for the purpose of appetite suppression or weight loss when prescribed solely for the purposes of losing weight. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of morbid obesity for which Benefits are provided as described under *Obesity Surgery* in *Section 1: Covered Health Services*.
7. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes for which Benefits are provided as described *Durable Medical Equipment* and *Diabetes Treatment* in *Section 1: Covered Health Services*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
9. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins. This exclusion does not apply to vitamins that have an A or B recommendation from the *U.S. Preventive Services Task Force (USPSTF)* that are required to be covered under the *Patient Protection and Affordable Care Act (PPACA)*.
10. Unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Service, unless Medically Necessary.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 4.)
15. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. However, this exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such

determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the *U.S. Preventive Services Task Force* (*USPSTF*) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Services*.

16. Any oral non-sedating antihistamine or antihistamine-decongestant combination.
17. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of a health condition, except as described under *Enteral Formula and Amino Acid-Modified Food Products* and *Phenylkeonuria (PKU) Treatment* in *Section 1: Covered Health Services*.
18. Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
19. Prescription Drug Products when prescribed as sleep aids.
20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Medical marijuana.
22. Dental products, including but not limited to prescription fluoride topicals. This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in *Section 10: Pediatric Dental Services*.
23. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product, unless Medically Necessary. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. Diagnostic kits and products.
25. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Urgent Requests

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

External Review

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

Expedited External Review

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

Defined Terms for Outpatient Prescription Drug Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of this *Certificate*:

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available. An Ancillary Charge will not apply if it is Medically Necessary for you to take the higher tier Prescription Drug Product.

Annual Drug Deductible - the amount you are required to pay for covered Tier 2, Tier 3 and Tier 4 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Services Schedule of Benefits* for details about how the Annual Drug Deductible applies.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

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

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Infertility - means either (1) the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception. In addition, in order to be eligible for Benefits, the Covered Person must also have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

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. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Network Pharmacy - a pharmacy that has:

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

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill.

A Prescription Drug Product includes a drug approved by the U.S. Food and Drug Administration, which is prescribed for a use that is different from the use for which the U.S. Food and Drug Administration approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must be recognized for the specific treatment for which the drug is being prescribed by any of the following: (1) the *American Hospital Formulary Service's Drug Information*; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: *Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium,* or *Thomson Microdex DrugDex;* or (3)

it is recommended by two articles from major peer reviewed medical journals. However, there is no coverage for any drug that the U.S. Food and Drug Administration or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits will also include Medically Necessary Covered Health Services associated with the administration of a drug subject to the conditions of this Policy.

A Prescription Drug Product includes a drug approved by the U.S. Food and Drug Administration prescribed to treat cancer during certain clinical trials as described in the *Certificate of Coverage.*

A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.
- Disposable devices which are Medically Necessary for the administration of a covered outpatient Prescription Drug Product.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products include orally administered anticancer medications used to kill or slow the growth of cancerous cells. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

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