UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan EFSZ

of

Ritalka Inc

Group Number: 933388

Effective Date: January 1, 2026

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UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

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

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

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

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

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

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

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. Prior authorization does not apply to Emergency Health Care Services.

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

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that

your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

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

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

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

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. Once authorization is provided, we will not revoke, limit, condition or restrict a prior authorization unless there is evidence of fraud or misinformation.

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

Care Management

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

Special Note Regarding Medicare

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

What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a calendar year basis.

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

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	***Network*** $4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family. ***Out-of-Network*** $5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, when applicable.	***Network*** $7,000 per Covered Person, not to exceed $14,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $10,000 per Covered Person, not to exceed $20,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Payment Term And Description	Amounts
• Co-payments or Co-insurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 30% *Air Ambulance* 30% ***Out-of-Network*** Same as Network	 Yes Yes Same as Network	 Yes Yes Same as Network
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 30% *Air Ambulance* 30%	 Yes Yes	 Yes Yes

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network *Ground Ambulance* 50% *Air Ambulance* Same as Network	 Yes Same as Network	 Yes Same as Network
2. Cellular and Gene Therapy			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Out-of-Network Benefits are not available.		
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	***Network*** 30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
5. Dental Services - Accident Only			
	Network 30% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	***Network*** 30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service.	***Network*** 30%	Yes	Yes

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*. Any applicable Out-of-Network cost-shares will be applied to your Network Out-of-Pocket Limit and Network Annual Deductible.	***Out-of-Network*** Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits as described under Fertility Preservation for Iatrogenic Infertility and for related services as described under Preimplantation Genetic Testing (PGT) and Related Services. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician's Office Services - Sickness and Injury below.	***Network*** 30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
11. Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

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

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

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

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with, outpatient speech therapy limits as described under *Habilitative Services* and *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*.		
12. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment.	*Outpatient* 30%	Yes	Yes

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*			
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 50%	Yes	Yes
13. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	***Network*** 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
14. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving			

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** 30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
15. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
16. Hospital - Inpatient Stay			
Prior Authorization Requirement			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to 120 hours of communicator or interpreter services for ventilator-dependent Covered Persons.	***Network*** 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient	***Network*** 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 30% None, for the first diagnostic mammogram or breast ultrasound in a	 Yes Yes, when Benefits are subject to Co-insurance	 Yes Yes, except for the first service in a year Yes, when

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Mammogram; additional diagnostic services and testing after a mammogram	year; 30% per service for any subsequent diagnostic mammogram or breast ultrasound in that year ***Out-of-Network*** 50% ***Network*** None subject to any applicable Annual Deductible ***Out-of-Network*** None subject to any applicable Annual Deductible	 Yes Yes Yes	Benefits are subject to Co-insurance Yes No No
18. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 30% None, for the first breast MRI in a year; 30% per service for	 Yes Yes, when Benefits are subject to Co-	 Yes Yes, except for the first service in

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	any subsequent breast MRI in that year ***Out-of-Network*** 50%	insurance Yes	a year Yes, when Benefits are subject to Co-insurance Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA);* psychological testing and transcranial magnetic stimulation. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network *Inpatient* 30% *Outpatient* ***Outpatient Office Visit*** 30% ***Outpatient Other***	 Yes Yes	 Yes Yes

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs 30%	Yes	Yes
	Intensive Behavioral Therapy 30%	Yes	Yes
	All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment 30%	Yes	Yes
	Out-of-Network *Inpatient* 50%	Yes	Yes
	Outpatient ***Outpatient Office Visit*** 50%	Yes	Yes
	Outpatient Other *Partial Hospitalization/Day Treatment/High*		

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Intensity Outpatient/Intensive Outpatient Programs 50%	Yes	Yes
	Intensive Behavioral Therapy 50%	Yes	Yes
	All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment 50%	Yes	Yes
20. Ostomy Supplies			
Limited to $2,500 per year.	***Network*** 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
21. Pharmaceutical Products - Outpatient			
Certain coupons, offers, assistance programs, or discounts *(Coupons)* from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your applicable deductible, Co-payment, and/or Co-insurance may vary when you use a	***Network*** 30%	Yes	Yes

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable deductible, Co-payment, and/or Co-insurance.	***Out-of-Network*** 50%	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
23. Physician's Office Services - Sickness and Injury			
	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
24. Pregnancy - Maternity Services			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network **Prenatal Care Services** None	No	No
	All Other Maternity Services including postdelivery care Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
	Out-of-Network **All Other Maternity Services including postdelivery care** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
25. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will	***Network***		

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
be the same as, and combined with, those stated under *Infertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.	30% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
26. Preventive Care Services			
Physician office services	***Network*** None ***Out-of-Network*** Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.
Lab, X-ray or other preventive tests	***Network*** None ***Out-of-Network*** Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.
Breast pumps	***Network*** None ***Out-of-Network*** Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.
27. Prosthetic Devices			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Network*** 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
28. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network***		

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 52 visits of physical therapy. • 52 visits of occupational therapy. • 52 Manipulative Treatments. • 52 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.	***Network*** 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 30% None, for the first diagnostic	 Yes Yes, when Benefits are	 Yes Yes, except for the first service in

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	colonoscopy in a year; 30% per date of service for any subsequent diagnostic colonoscopy in that year ***Out-of-Network*** 50%	subject to Co-insurance Yes	a year Yes, when Benefits are subject to Co-insurance Yes
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to 60 days per year.	***Network*** 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
32. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Allowed Amount.			
	Network 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
33. Temporomandibular and Craniomandibular Joint Disorder (TMD and CMD) Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before TMJ services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
34. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services,			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
35. Transplantation Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Out-of-Network Benefits are not available.		
36. Urgent Care Center Services			
	Network 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
37. Urinary Catheters			
	Network 30% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes

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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
38. Virtual Care Services			
Network Benefits are available only when services are delivered through a Preferred Virtual in-Network Provider. You can find a Preferred Virtual in-Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	***Network*** None ***Out-of-Network*** Out-of-Network Benefits are not available.	Yes Out-of-Network Benefits are not available.	No Out-of-Network Benefits are not available.
Additional Benefits Required By Minnesota Law			
39. Autism Spectrum Disorders			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in the *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
40. Children's Health Supervision Services			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
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Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network None ***Out-of-Network*** None	 No No	 No No
41. Cleft Lip and Cleft Palate Services			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
42. Dental Anesthesia			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	each Covered Health Care Service category in this *Schedule of Benefits.*		
43. Lyme Disease Treatment			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
44. Port-Wine Stain Treatment			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
45. Rare Disease or Condition Services			

When service limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Same as Network		
46. Residential Treatment for Emotionally Disabled Children			
Prior Authorization Requirement Any applicable authorization requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.			
	Network Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*. ***Out-of-Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
47. Scalp Hair Prostheses and Wigs			
	Network 30%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

Allowed Amounts

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

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

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

Network Benefits

Allowed Amounts are based on the following:

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

Out-of-Network Benefits

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

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either:
    - Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and

consent criteria but unforeseen, urgent medical needs arise at the time the services are provided),

- Services where a Network provider sends a specimen taken from you in the Network provider's practice setting to an out-of-Network laboratory, pathologist, or other medical testing facility,

the Allowed Amount is based on one of the following in the order listed below as applicable:

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

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

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

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

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

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

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

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

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

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
    - 135% of *CMS* for the same or similar professional Mental Health Care and Substance-Related and Addictive Disorder Services provider.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

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

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

Provider Network

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

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

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

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

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card. Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Such Network providers are not listed in your provider directory; however, if you contact us, we will assist you in determining whether a specific provider is contracted with us for the Covered Health Care Service that you require. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Continuity of Care

If you are under the care of a Network Physician and the Network Physician's contract was terminated by us or you have changed health plans, you may request to continue receiving care from that provider for:

- Up to 90 days of coverage for Covered Persons who are undergoing treatment within the first trimester of pregnancy.
- Up to 120 days if you are engaged in a current course of treatment for one or more of the following conditions:
    - An acute condition.
    - A life-threatening mental or physical illness.
    - Pregnancy.
    - A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death.

- A disabling or chronic condition that is in an acute phase.

- The rest of the Covered Person's life if a Physician certifies that the enrollee has an expected lifetime of 180 days or less.
- Up to 120 days if you:
  - Are receiving culturally appropriate services and we do not have a Physician in our Network with special expertise in the delivery of those culturally appropriate services within appropriate time and distance requirements.
  - Do not speak English and we do not have a provider in our Network who can communicate with you either directly or through an interpreter within appropriate time and distance requirements.

Continuity of care will only be provided if the Physician agrees to all of the following:

- Accept as payment in full, the lesser of our reimbursement rate for Network Physicians for the same or similar service, or your Physicians regular fee for that service.
- Adhere to our prior authorization requirements.
- Provide us with all necessary medical information related to your care.

Continuity of care will not be provided if the Physician was terminated from the Network for cause.

Preferred in-Network Providers

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

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

Health Care Services from Out-of-Network Providers Paid as Network Benefits

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

We will pay Network Benefits for the following Covered Health Care Services, even if the provider is an Out-of-Network provider:

- The voluntary planning of the conception and bearing of children (does not include abortion services).
- The diagnosis of infertility.
- Testing for a sexually transmitted disease including AIDS or other HIV-related conditions.
- Treatment of a sexually transmitted disease excluding AIDS or other HIV-related conditions.

Limitations on Selection of Providers

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

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

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

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

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

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

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

How Do You Contact Us?

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

Your Responsibilities

Eligibility, Enrollment, and Required Contributions

Benefits are available to you once you are enrolled for coverage under the Policy. The Group will apply the eligibility rules.

- Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:
  - Your enrollment must be in accordance with the rules of the Policy issued to your Group, including the eligibility rules.
  - You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Subscriber or Dependent as defined in *Section 9: Defined Terms* and meet the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*.
- Your Benefits are no longer available as described in *Section 4: When Coverage Ends.*

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Requests for prior authorization are allowed without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Continuity of care - prior authorization

You may be able to continue to receive health care services under prior authorizations approved by your previous health benefit plan for up to 60 days of coverage under this Policy. In order to obtain coverage for this 60-day time period, you or your attending Physician must submit documentation of the previous

prior authorization to us. During this 60-day time period, we may conduct our own utilization review of these services.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*. Please note that waived Co-payments and/or deductibles by the provider do not count toward out-of-pocket 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 the Policy's exclusions.

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Unauthorized provider services

Out-of-Network provider balance billing prohibition

Balance billing is prohibited when you received services from:

- An out-of-Network provider at a Network hospital or ambulatory surgical center, as described by the *No Surprises Act*, including any federal regulations under that act;
- A Network provider that sends a specimen taken from you in the Network provider's practice setting to an out-of-Network laboratory, pathologist, or other medical testing facility; or
- An out-of-Network provider or facility providing Emergency Health Care Services, and other services as described in the requirements of the *No Surprises Act*.

The services noted above, as defined in the *No Surprises Act*, and any federal regulations adopted under that act, are subject to balance billing if you provide informed consent prior to receiving services from the out-of-Network provider acknowledging that the use of an out-of-Network provider, or the services to be rendered by the out-of-Network provider, may result in costs not covered by us, which the provider may bill you for later. The informed consent must comply with all requirements of the *No Surprises Act*, including any federal regulations adopted under the act.

Cost-sharing requirements and independent dispute resolution

If you receive services as noted above:

- Your financial responsibility for the out-of-Network provider services shall be the same cost-sharing requirement, including Co-payments, deductibles, Co-insurance, coverage restrictions, and coverage limitations, as those applicable services received by the Covered Person from a Network provider. We must apply any Covered Person's cost sharing requirements, including Co-payments, deductibles, and Co-insurance, for out-of-Network provider services to the Covered Person's annual Out-of-Pocket Limit to the same extent payments to a Network provider would be applied.
- We will attempt to negotiate reimbursement, less any applicable cost sharing, for the out-of-Network provider services with the out-of-Network provider. If the attempt to negotiate reimbursement for the out-of-Network provider services do not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the *No Surprises Act*, including any federal regulations adopted under the act.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this *Certificate* and the Group *Application*.

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

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

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

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

Please note that no referral is required for obstetric or gynecologic services.

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. Ambulance Services

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

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

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

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

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

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

2. Cellular and Gene Therapy

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

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

3. Clinical Trials

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

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

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

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

For purposes of this Benefit, a "qualified individual" means a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

- The referring Physician is participating in the trial and has concluded that the Covered Person's participation in the trial would be appropriate; or
- The Covered Person provides medical and scientific information establishing that the Covered Person's participation in the trial is appropriate because the Covered Person meets the conditions descried in the trial protocol.

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and designed exclusively to test toxicity or disease pathophysiology. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of

peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

- Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
- Ensures unbiased review by qualified persons who have no interest in the outcome of the review.

- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- Exempt from having such an investigational new drug application.
- The clinical trial must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial.

4. Congenital Heart Disease (CHD) Surgeries

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

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

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

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

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

5. Dental Services - Accident Only

Dental services when all of the following are true:

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

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

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

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

- Treatment must be completed within 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 accidental Injury are limited to the following:

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

6. Diabetes Services

Diabetes Services are available for Covered Persons with gestational, type I or type II diabetes.

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals working in a program consistent with the national standards of diabetes self-management education as established by the *American Diabetes Association*.

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

Diabetic Self-Management Items

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

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

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

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).

- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

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

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

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

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

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

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

Please refer to the *Schedule of Benefits* for any prior authorization requirements and level of Benefit. For additional information regarding prior authorization, including criteria used in making coverage decisions and information on limitations and exclusions for this Benefit, you may contact us at www.myuhc.com or the telephone number or address on your ID card.

8. Emergency Health Care Services - Outpatient

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

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

9. Enteral Nutrition

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

Examples include, but are not limited to:

- Special dietary treatment for phenylketonuria when recommended by a Physician.
- Amino acid-based formulas when Medically Necessary, including but not limited to the following conditions:
  - Cystic fibrosis.
  - Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders.
  - IgE mediated allergies to food proteins.

- Food protein-induced enterocolitis syndrome.
- Eosinophilic esophagitis.
- Eosinophilic gastroenteritis.
- Eosinophilic colitis.
- Mast cell activation syndrome.

10. Fertility Preservation for Iatrogenic Infertility

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

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

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

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

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

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician including Gender Affirming Health Care Services as defined under *Section 9: Defined Terms*.

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

12. Habilitative Services

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

Habilitative services are limited to:

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

- Cognitive therapy.

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

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

The following are not habilitative services:

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

We may require the following be provided:

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

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

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

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

13. Hearing Aids

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

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

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

Benefits do not include bone anchored hearing aids except for craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid or hearing loss severe enough that it would not be remedied by a wearable hearing aid. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*.

14. Home Health Care

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

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

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

15. Hospice Care

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

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

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

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

16. Hospital - Inpatient Stay

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

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Communicator or interpreter services performed by a private duty nurse or personal care assistant to a ventilator-dependent Covered Person during a transition period to assure adequate training of the Hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. This is limited to 120 hours of communicator or interpreter services for ventilator-dependent Covered Persons.

17. Lab, X-Ray and Diagnostic - Outpatient

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

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

Benefits include:

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

Benefits include:

- Pap smears.
- Surveillance tests for those at risk for ovarian cancer.
    - "At risk for ovarian cancer" means;
        - Having a family history;
            - With one or more first or second degree relatives with ovarian cancer;
            - Of clusters of women relatives with breast cancer; or
            - Of nonpolyposis colorectal cancer; or
        - Testing positive for BRCA1 or BRCA2 mutations.
    - "Surveillance tests for ovarian cancer" means annual screening using:
        - CA-125 serum tumor marker testing;
        - Transvaginal ultrasound;
        - Pelvic exam; or
        - Other proven ovarian cancer screening tests currently being evaluated by the *FDA* or by the *National Cancer Institute*.
- Screening mammography including digital breast tomosynthesis for those at risk for breast cancer and is covered as a preventive item or service. "At risk for breast cancer" means;
    - Having a family history with one or more first- or second-degree relatives with breast cancer;
    - Testing positive for BRCA1 or BRCA2 mutations;
    - Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
    - Having a previous diagnosis of breast cancer.
- Additional diagnostic services or testing after a mammogram as determined by a Physician.
- Prostate cancer screening including a prostate-specific antigen blood test and a digital rectal exam for:

- Men age 40 or older who are symptomatic or in a high-risk category.
- All men age 50 or older.

- Biomarker Testing for the purposes of diagnosis, treatment, management, and monitoring illness or disease if the test provides Clinical Utility.
- Rapid Whole Genome Sequencing (rWGS) testing if the Covered Person is:
  - 21 years of age or younger.
  - Has a complex or acute illness of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma.
  - Is receiving inpatient Hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit.

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

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

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply when services are provided in a Physician's office.

18. Major Diagnostic and Imaging - Outpatient

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

Benefits include:

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply when services are provided in a Physician's office.

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

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

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a provider as described below within this paragraph and have been determined to be Medically Necessary care. For the purpose of this Benefit, Medically Necessary care means Covered Health Care Services appropriate, in terms of type, frequency, level, setting and duration, to the Covered Person's diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically

manages the condition, procedure, or treatment at issue and must help restore or maintain the Covered Person's health or prevent deterioration of the Covered Person's condition.

Benefits include the following levels of care:

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

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

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
    - Neurodevelopmental and behavioral health treatments and management.

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

Benefits also include Mental Health Care Services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must receive a copy of the court order and the behavioral care evaluation. Benefits include the:

- Evaluation if performed by a Network provider.
- The plan shall be financially responsible for the care included in the court-ordered individual treatment plan if the care is covered by the *Certificate* and ordered to be provided by a Network provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination under our utilization procedures.

Benefits are provided for Substance-Related and Addictive Disorder treatment while a Covered Person is committed to the custody of the *Commissioner of Corrections* following a conviction for a first-degree driving while impaired offense if both of the following are true:

- A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment that treatment may be appropriate and includes this determination as part of the sentencing order.
- The *Department of Corrections* makes a determination that treatment is appropriate based on a chemical assessment conducted while the individual is in the custody of the department.

Referral or direction from the Mental Health/Substance-Related and Addictive Disorders Designee is not required for Substance-Related and Addictive Disorders treatment received while the Covered Person is committed to the custody of the *Commissioner of Corrections*. The treatment provided by the *Department of Corrections* that meets the requirements noted directly above shall not be subject to a separate medical necessity determination under our utilization review procedures.

Mental Health Parity Disclosure: You have rights to parity in Mental Health Care and Substance-Related and Addictive Disorders Services as required by the federal *Mental Health Parity and Addiction Equity Act* and *Minnesota Statutes, section 62Q.47*. These laws require that Mental Health Care and Substance-Related and Addictive Disorders Services can be no more restrictive than for similar medical services. If you have questions regarding these rights, you may call us at the telephone number on your ID card, file a complaint with us, or file a complaint with the Minnesota *Department of Commerce*.

20. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

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

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

21. Pharmaceutical Products - Outpatient

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

Benefits include Pharmaceutical Products such as antibiotics, medication therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS) and must be recommended by your Physician.

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

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

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product(s) for which Benefits are provided as described under the *Outpatient Prescription Drug Rider* first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

When a step therapy requirement applies to a Pharmaceutical Product, your provider may request an exception:

- For non-urgent step therapy exception requests, a review will be completed within five (5) days once all information needed to process the request has been received.
- For urgent step therapy requirements, a review will be completed within 72 hours once all the information needed to process the request has been received.

If your step therapy request is denied, please refer to *Section 6: Questions, Complaints and Appeals* for additional information on appealing an Adverse Determination.

A step therapy exception request will be approved if at least one of the following conditions exist:

- The Pharmaceutical Product required under the step therapy requirements is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the Pharmaceutical Product or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:
  - Cause an adverse reaction to you;
  - Decrease the ability for you to achieve or maintain reasonable functional ability in performing daily activities; or
  - Cause physical or mental harm to you.

Certain Specialty Pharmaceutical Products are eligible for coupons, offers, assistance programs, or discounts (*Coupons*) from pharmaceutical manufacturers or affiliates that may reduce the cost for your Specialty Pharmaceutical Product. We may help you determine whether your Specialty Pharmaceutical Product is eligible for this reduction. If you are eligible and redeem a *Coupon* from a pharmaceutical manufacturer or affiliate, your applicable deductible, Co-payment, and/or Co-insurance may vary (*Adjusted Variable Co-payment*) and will be reflected as deductible, Co-payment, and/or Co-insurance in your Explanation of Benefits. Our payment will be determined based on the difference between the Allowed Amount minus the *Adjusted Variable Co-payment* described above. The redeemed Coupon value will count toward any applicable deductible or Out-of-Pocket Limits. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the applicable deductible, Co-payment and/or Co-insurance as described in the *Schedule of Benefits*.

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

22. Physician Fees for Surgical and Medical Services

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

23. Physician's Office Services - Sickness and Injury

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

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

- Education is required for a disease in which patient self-management is a part of treatment.

- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include the following:

- Allergy injections.
- Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS). Treatments that are covered must be recommended by your Physician and include but are not limited to, antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin. Benefits for antibiotics, medication therapies to manage neuropsychiatric symptoms, plasma exchange and immunoglobulin are described under *Pharmaceutical Products - Outpatient* or as described under the *Outpatient Prescription Drug Rider*.

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

24. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. For purposes of this Benefit, "prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the Pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by *Standards for Obstetric-Gynecologic Services* issued by the *American College of Obstetricians and Gynecologists*.

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

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

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

Benefits are available without cost share for expenses related to transferring the mother, newborn, and newborn siblings when a Physician or health care provider acting within their scope of practice recommends the mother and/or newborn to be transferred to a different medical facility.

If the duration of the Inpatient Stay is less than as described above, post-delivery outpatient care will be provided as follows:

- One home visit by a registered nurse, conducted within four days following the discharge of the mother and newborn child, which includes but is not limited to:
  - Parent education;
  - Assistance and training in breast and bottle feeding; and
  - Conducting any necessary and appropriate clinical tests.

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

For purposes of this Benefit, "comprehensive postnatal visit" means a visit with a Physician that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception and birth

spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Benefits are provided for the following:

- A comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery;
- Any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery; and
- A comprehensive postnatal visit with a health care provider from 12 weeks from the date of delivery.

Benefits are available for abortions, meaning any medical treatment intended to induce the termination if a pregnancy with a purpose other than producing a live birth, and abortion related services, including pre-abortion and follow up services.

25. Preimplantation Genetic Testing (PGT) and Related Services

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

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

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

26. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required 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*, such as screening mammography (including digital breast tomosynthesis if you are at risk for breast cancer). Benefits for colorectal cancer screenings that do not have in effect a rating of "A" or "B" are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

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

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

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.

- All preexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined in any guidance by the *United States Preventive Services Task Force* or the *Centers for Disease Control*, including the June 11, 2019, Preexposure Prophylaxis for the Prevention of HIV Infection United States Preventive Services Task Force Recommendation Statement.
- All postexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the *United States Preventive Services Task Force* or the *Centers for Disease Control*.

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

27. Prosthetic Devices

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

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

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

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

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

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

28. Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness, or other diseases of the involved part or when such service is performed on a covered Dependent child because of congenital disease or Congenital Anomaly which has resulted in a functional defect as determined by the attending Physician.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and Covered Person. Services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

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

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

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

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

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

30. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Benefits include colorectal cancer screening tests for men and women when ordered or provided by a Physician in accordance with the standard practice of medicine. Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.

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

Benefits include:

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

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply when services are provided in a Physician's office.

31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

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

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

32. Surgery - Outpatient

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

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

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

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

Benefits include:

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply when services are provided in a Physician's office.

33. Temporomandibular and Craniomandibular Joint Disorder (TMD and CMD) Services

Services for the evaluation and treatment of TMD and CMD and associated muscles.

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

Benefits are provided for surgical and non-surgical treatment that is administered or prescribed by a *Doctor of Medicine* or dentist.

Non-surgical treatment including but not limited to:

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

Benefits for surgical services including but not limited to:

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

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

34. Therapeutic Treatments - Outpatient

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

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

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

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

Benefits include:

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

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply when services are provided in a Physician's office.

35. Transplantation Services

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

Examples of transplants for which Benefits are available include:

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

As technology changes, the list of transplants may be modified to add or delete certain transplants, when appropriate.

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

- Identification.
- Evaluation.

- Organ removal.
- Direct follow-up care.

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

36. Urgent Care Center Services

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

37. Urinary Catheters

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

Benefits include related urologic supplies for indwelling catheters limited to:

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

38. Virtual Care Services

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

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

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

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

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

Additional Benefits Required By Minnesota Law

39. Autism Spectrum Disorders

Benefits are provided for Covered Health Care Services for Enrolled Dependent children for the diagnosis, evaluation, multidisciplinary assessment and Medically Necessary care who have Autism Spectrum Disorders. Coverage includes, but is not limited to the following:

- Early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;
- Neurodevelopmental and behavioral health treatments and management;
- Speech therapy;
- Occupational therapy;

- Physical therapy; and
- Medications (as provided under the *Outpatient Prescription Drug Rider)*.

In addition to the Benefits listed under the *Mental Health Care and Substance-Related and Addictive Disorders Services* and the *Habilitative Services* sections, we will provide coverage for the diagnosis, evaluation, and assessment of the Enrolled Dependent child's developmental skills, functional behavior, needs, and capacities.

As specified by Minnesota law:

- The coverage under this section includes treatment that is in accordance with an individualized treatment plan prescribed by the treating Physician or mental health professional.
- We will not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an Eligible Person solely because the individual is diagnosed with an Autism Spectrum Disorder.
- We may request an updated treatment plan only once every six months, unless we and the treating Physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.
- An independent progress evaluation conducted by a mental health professional with expertise and training in Autism Spectrum Disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

40. Children's Health Supervision Services

For purposes of this Benefit, "child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age 6 and appropriate immunizations from ages 6 to 18, as defined by *Standards of Child Health Care* issued by the *American Academy of Pediatrics*. Benefits include at least:

- Five visits from birth to 12 months.
- Three visits from 12 months to 24 months.
- One visit per year from 24 months to 72 months.

41. Cleft Lip and Cleft Palate Services

Inpatient and outpatient services received to treat or manage birth defects known as cleft lip and cleft palate. Benefits include both medical and dental treatment of cleft lip and cleft palate up to the limiting age for an Enrolled Dependent child coverage. Examples of Benefits include, but are not limited to orthodontic and oral surgery. Benefits for Enrolled Dependent children age 19 or older are limited to expenses from treatment that was scheduled prior to the attainment of age 19.

If orthodontic services are eligible for coverage under a dental insurance plan, the dental plan shall be primary and this Policy shall be secondary. Payment for dental or orthodontic treatment not related to cleft lip or cleft palate is not covered under this Benefit.

42. Dental Anesthesia

Anesthesia and associated Hospital or Alternate Facility charges for dental care provided to a Covered Person who:

- Is a child under age five.
- Is disabled.
- Has a medical condition and requires hospitalization or general anesthesia for dental treatment.

Benefits are also provided for general anesthesia and treatment provided by a dentist for a medical condition that is normally covered by this Policy, regardless of whether the services are provided in a Hospital, Alternate Facility, or dental office. This Policy does not provide Benefits for dental services. Excluded dental services are described under *Dental* in *Section 2: Exclusions and Limitations*.

43. Lyme Disease Treatment

Treatment of Lyme disease.

44. Port-Wine Stain Treatment

Elimination of or maximum feasible treatment of port-wine stains.

45. Rare Disease or Condition Services

Unrestricted access to services from a Physician for the diagnosis, monitoring and treatment of a rare disease or condition.

For purposes of this Benefit "rare disease or condition" means any disease or condition:

- That affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;
- That affects more than 200,000 persons in the United States and a drug for treatment has been designated as such pursuant to *United States Code, title 21, section 360bb*;
- That is labeled as a rare disease or condition on the Genetic and Rare Disease Information Center list created by the *National Institutes of Health*; or
- For which a Covered Person:
- Has received two or more clinical consultations from a primary care provider or specialty provider that is specific to the presenting complaint;
- Had documentation in the Covered Person's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- Had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

Any services provided, referred for, or ordered by an out-of-Network provider for a Covered Person, who, before receiving and being notified of a definitive diagnosis, satisfied the requirements above, must not have more restrictive cost-sharing or service limitations than the requirements for Network medical treatment even if the subsequent definitive diagnosis does not meet the definition of rare disease or condition as noted above. Once the Covered Person is definitively diagnosed with a disease or condition that does not meet the definition of rare disease or condition as noted above, and the Covered Person has been notified of the diagnosis, any services provided, referred for, or ordered by an out-of-Network provider related to the diagnosis must not have more restrictive cost-sharing or service limitations than the requirements for Network medical treatment for up to 60 days, providing time for care to be transferred to a qualified Network provider and to schedule needed Network appointments. After this 60-day period, subsequent services provided, referred for, or ordered by an out-of-Network provider related to the diagnosis will be processed as out-of-Network.

If you receive services from an out-of-Network provider who is outside the State of Minnesota, you could potentially be billed by the provider for an amount above what we are required to pay the provider, in accordance with *Minnesota Statute Section 62Q.451, subd. 5.*

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

This does not apply to medications obtained from a retail pharmacy.

46. Residential Treatment for Emotionally Disabled Children

Treatment of emotionally disabled Enrolled Dependent children in a residential treatment facility licensed by the *Commissioner of Human Services*. An emotionally disabled child shall have the meaning set forth by the *Commissioner of Human Services* in the rules relating to residential treatment facilities.

47. Scalp Hair Prostheses and Wigs

Wigs and other scalp hair prostheses regardless of the reason for hair loss.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

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

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

A. Alternative Treatments

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

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia, except that Benefits for hospitalizations and anesthesia are provided as described under *Dental Anesthesia* in *Section 1: Covered Health Care Services*.

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

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer, cleft lip, or cleft palate except when Benefits for cleft lip and cleft palate treatment are provided as described under *Cleft Lip and Cleft Palate Services* in *Section 1: Covered Health Care Services*.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.* This exclusion does not apply to TMD and CMD services for which Benefits are described under *Temporomandibular and Craniomandibular Joint Disorder (TMD and CMD) Services* in *Section 1: Covered Health Care Services*.
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to newborn children receiving care of cleft palate if the treatment was schedule or initiated prior to turning 19.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.

- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service. Examples of excluded items are blood pressure monitors, oximeters or thermometers. This exclusion does not apply to *Durable Medical Equipment (DME), Orthotics and Supplies* as described under *Section 1: Covered Health Care Services*.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not impact medical Benefits and services rendered in an office visit, facility or alternate setting and are provided as described under your *Outpatient Prescription Drug Rider*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration. Please see your *Outpatient Prescription Drug Rider* for applicable coverage requirements.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. Please see your *Outpatient Prescription Drug Rider* for applicable coverage requirements.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to

another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. Such determinations may be made up to six times during a calendar year.

9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product or prescription drug product as described in the *Outpatient Prescription Drug Rider*, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Refer to the definitions of *Experimental or Investigational Service(s)* and *Unproven Services* under *Section 9: Defined Terms*.

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

F. Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.
   - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
    - Abdominoplasty.
    - Blepharoplasty.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction.
    - Mastopexy.
    - Pectoral implants for chest masculinization.
    - Rhinoplasty.
    - Skin resurfacing.

H. Medical Supplies and Equipment

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

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

3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusion listed directly below applies to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.*

Conversion therapy that seeks to change a Covered Person's sexual orientation or gender identity.

J. Nutrition

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

K. Personal Care, Comfort or Convenience

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

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin. This exclusion does not apply to *Port-Wine Stain Treatment* as described under *Section 1: Covered Health Care Services*.
    - Treatment for spider veins.
    - Sclerotherapy treatment of veins.
    - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.

5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. All rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected.

5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly as described under the *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in *Section 1: Covered Health Care Services*.

6. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. An example of the same therapeutic effects includes, but is not limited to: physiological treatments and procedures to reduce pain, increase circulation and increase mobility of soft tissues in the treatment of strain.

7. Biofeedback.

8. The following services for the diagnosis and treatment of TMD: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; occlusal adjustment; and dental restorations as these services are considered to be unproven for Temporomandibular Joint Disorder Services diagnosis and treatment.

9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors, cancer or TMD or CMD services. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea, temporomandibular joint syndrome or craniomandibular joint disorder. Benefits for TMD and CMD services are described under *Temporomandibular and Craniomandibular Joint Disorder (TMD and CMD) Services* in *Section 1: Covered Health Care Services*.

10. Surgical and non-surgical treatment of obesity.

11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

12. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.

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

14. Intracellular micronutrient testing.

N. Providers

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

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

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

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

   This exclusion does not apply to mammography or Emergency Health Care Services.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

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

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

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

3. Costs of donor eggs and donor sperm.

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

P. Services Provided under another Plan

1. Health care claims paid by other coverage required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion applies only to the extent that health care claims are paid by another carrier. This plan's coordination of benefits rules will be used to determine payment obligations where applicable.
2. Claims resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services were paid under a medical expense payment provision of an automobile insurance policy.
3. Health care claims paid for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Q. Transplants

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

R. Travel

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

S. Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides. This exclusion does not apply as described under *Hospital - Inpatient Stays* or *Private Duty Nursing* in *Section 1: Covered Health Care Services.*
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act*.
11. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

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

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

U. All Other Exclusions

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

2. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

3. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply to required services as explained under the *Continuity of Care* section in the *Schedule of Benefits*.

4. Health care services when you have no obligation to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.

5. Charges in excess of the Allowed Amount or in excess of any specified limitation.

6. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

7. Autopsy, except as described under *Do We Require Examination of Covered Persons* in *Section 8: General Legal Provisions*.

8. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

9. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. Examples of such services are Physician, anesthesia or Hospital care related to non-Covered Health Care Services. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services, including Emergency Health Care Services, if the service treats complications that arise from the non-Covered Health Care Service.

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

10. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services.

Section 3: When Coverage Begins

How Do You Enroll?

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

What If You Are Hospitalized When Your Coverage Begins?

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

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

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

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

What If You Are Enrolled for Medicare?

Your Benefits may be reduced if you are enrolled for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *How Are Benefits Paid When You Are Covered under Medicare?* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

Eligibility for enrollment is administered by the Group consistent with the Policy which includes this *Certificate* and Group *Application*.

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group in accordance with the eligibility rules. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible, except for newborn and adopted children.

Newborn children will be covered from the moment of birth for Sickness, Injury, congenital malformation, or premature birth even if the Subscriber has not enrolled the child for coverage. Coverage for adopted children will begin on the date that the child is placed for adoption even if the Subscriber has not enrolled the child for coverage. However, if any Premium is required in order for a newborn or adopted child to be covered, we shall be entitled to all Premiums that would have been collected had we been made aware of the new Dependent. We may reduce Benefits by the amount of past due Premiums that apply to each new Dependent.

Please note that other employees may be added to the plan from time to time.

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

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

Newborn children will be covered from the moment of birth even if the Subscriber has not enrolled the child for coverage. Coverage for adopted children will begin on the date that the child is placed for adoption even if the Subscriber has not enrolled the child for coverage. However, if any Premium is required in order for a newborn or adopted child to be covered, we shall be entitled to all Premiums that would have been collected had we been made aware of the new Dependent. We may reduce Benefits by the amount of past due Premiums that apply to each new Dependent.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement 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 any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce 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 resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

Newborn children will be covered from the moment of birth even if the Subscriber has not enrolled the child for coverage. Coverage for adopted children will begin on the date that the child is placed for adoption even if the Subscriber has not enrolled the child for coverage. However, if any Premium is required in order for a newborn or adopted child to be covered, we shall be entitled to all Premiums that would have been collected had we been made aware of the new Dependent. We may reduce Benefits by the amount of past due Premiums that apply to each new Dependent.

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends.

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

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

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Disabled Dependent

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

- The Enrolled Dependent is not able to support him/herself because of developmental disability, mental illness or disorder, or physical disability.
- The Enrolled Dependent depends mainly on the Subscriber for support and maintenance.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the Enrolled Dependent reached a certain age.

We may continue to ask you for proof that the Enrolled Dependent continues to be disabled and dependent. We will not ask for this information more than annually after the two-year period following the Enrolled Dependent's attainment of the limiting age.

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

Continuation of Coverage

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

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator if you would like assistance understanding the difference between *COBRA* and Continuation Coverage under Minnesota State Law.

If you have continuation of coverage under *COBRA* and your past employer changes their group health plan, your *COBRA* coverage will be changed to the new group health insurance plan chosen by the employer. This change in the health plan does not impact the continuation coverage end date.

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

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

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

Continuation Coverage under Minnesota State Law

Coverage under this Policy may continue when coverage would otherwise end due to one of the qualifying events listed below. To be eligible, you must be a Covered Person when the qualifying event occurs.

Qualifying events:

- Termination or lay-off (voluntary or involuntary) of the Subscriber from employment with the Group for any reason except gross misconduct. When this occurs, the Subscriber and Enrolled Dependents are eligible for continuation coverage until the earlier of:
    - 18 months after the Subscriber's termination or lay-off from employment.

- The date the Subscriber becomes covered under another group health plan.

- Dissolution of marriage. When this occurs, the former spouse and Dependent children are eligible for continuation coverage until the earlier of:
  - The date the Subscriber's former spouse becomes covered under any other group health plan.
  - The date coverage would otherwise terminate under the Policy.
- Death of the Subscriber. When this occurs, all Enrolled Dependents are eligible for continuation coverage until the earlier of:
  - The date the surviving spouse becomes covered under another group health plan.
  - The date coverage would have terminated under the Policy if the Subscriber had lived.
- Dependent child ceases to be eligible as a Dependent. When this occurs, the child is eligible for continuation coverage until the earliest of:
  - The date Coverage would otherwise terminate under the Policy.
  - 36 months after continuation was elected by the child.
  - The date the child becomes covered under another group health plan.
- Subscriber's entitlement to Medicare. When this occurs, the spouse and Dependent children are eligible for continuation coverage until the earliest of:
  - The date coverage would otherwise terminate under the Policy.
  - 36 months after continuation was elected by the spouse or Dependent child.
  - The date the spouse or Dependent child becomes covered under another group health plan.

Disabled Employees

- Subscriber becomes totally disabled. When this occurs, the Subscriber, spouse and Dependent Children are eligible for continuation coverage until the Subscriber is no longer totally disabled. For purposes of eligibility for continuation coverage, "totally disabled" means:
  - The inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment within the first two years of such disability.
  - After the first two years of such disability, the inability of the employee to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training be or reasonably become qualified.

Notification Requirements and Election Period for Continuation Coverage under Minnesota State Law

Notification Requirements

When continuation coverage eligibility is due to termination or lay-off, the Group shall provide the Covered Person with written notification of:

- The right to continuation coverage within 14 days of the termination of coverage.
- The Premium amount the Covered Person must pay monthly to the Group to retain coverage.
- The manner in which and the office of the Group to which the Premium payment must be made to retain coverage.

Election Period

When continuation coverage eligibility is due to termination or lay-off, the Subscriber must elect continuation within 60 days of the later of:

- The date the Subscriber's coverage would otherwise terminate.
- The date upon which notice of the right to continuation coverage is received.

When continuation coverage eligibility is due to the Subscriber's death, the survivor must pay the Premium for the continuation coverage within 90 days after notice of the requirement to pay the Premium. If no election is made in this time, notice of cancellation will be sent to the survivor's last known address at least 30 days before the cancellation.

When continuation eligibility is due to the Subscriber's death or a break in the marital relationship, the Group must provide the enrolled person with written verification of the cost of the continuation coverage promptly upon request at the time of eligibility for continuation coverage and at any time during the continuation period.

You should obtain an election form from the Group or the employer and, once election is made, forward all monthly Premiums to the Group for payment to us. You may also contact us for instructions necessary to elect continuation coverage. Please call using the telephone number listed on your ID card.

Required Premium Contributions

Any required premium contributions for the continuation coverage shall be paid on a monthly basis to the Group for remittance to us when continuation coverage eligibility is due to:

- Dissolution of marriage.
- Death of the Subscriber.
- Dependent child ceases to be eligible as a Dependent.
- Employee Enrollment for Medicare.
- Employee Total Disability.

In no event shall the amount of the Premium charged exceed 102 percent of the cost of the health plan for such period of coverage for other similarly situated Covered Persons to whom this event is not applicable, without regard to whether such cost is paid by the Group or the Covered Person. This premium limit applies when continuation coverage eligibility is due to:

- Termination or Lay-off.
- Dissolution of marriage.
- Death of the Subscriber.
- Dependent child ceases to be eligible as a Dependent.
- Employee Enrollment for Medicare.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

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

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

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

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

Required Information

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

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

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

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

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Payment of Benefits

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider

directly for services rendered to you. In the case of such payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

Any such payment to an out-of-Network provider:

- Is not an assignment of your Benefits under the Policy or of any legal or equitable right to institute any proceeding relating to your Benefits,
- Is not a waiver of the prohibition on assignment of Benefits under the Policy, and
- Will not preclude us from asserting that any purported assignment of Benefits under the Policy is invalid and prohibited.
- Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. 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 representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint.

You can contact the representative to request a complaint form which will include the following:

- The telephone numbers for the *Office of Health Care Consumer Assistance*, *Advocacy and Information* and the persons equipped to advise you on complaint resolution.
- The address to which the form must be sent.
- A copy of our internal complaint procedure and applicable time limits as listed in this section.
- The toll-free telephone number of the *Commissioner of Commerce* and notification that you have the right to submit the complaint to the *Commissioner of Commerce* at any time.

Upon receipt of a written complaint, we will notify you within 10 business days that the complaint was received, unless the complaint is resolved to your satisfaction within 10 business days.

We will provide written notification of our decision regarding your written complaint within 30 days of receiving it. If we are unable to make a decision within 30 days due to circumstances outside our control, we will notify you that it may take up to four additional business days to notify you of our decision. We will include the reason for the extension.

If the decision regarding a complaint is partially or wholly adverse to you, the notification of the adverse decision will inform you of your right to appeal the decision, our internal appeal process, and the process for initiating an appeal. The notification will also inform you of your right to submit the complaint to the *Commissioner of Commerce* for investigation and the toll-free telephone number for the *Commissioner of Commerce*. You may also submit the complaint with the *Department of Commerce* by On-line complaints: https://mn.gov/commerce/consumers/file-a-complaint/ or Email: consumer.protection@state.mn.us. The quickest and most efficient way to file a complaint is through the online portal.

How to Appeal a Complaint Decision

A qualified individual who was not involved in the complaint decision being appealed will be appointed to decide the appeal. The appeal process will permit the receipt of testimony, correspondence, explanation or other information deemed necessary by those investigating or presiding over the appeal.

An appeal may be submitted to us either in writing or by hearing.

If your appeal is in writing, we will provide written notice of the appeal decision and all key findings within 30 days of our receipt of your written notice of appeal. If your appeal is by hearing, we will give you written notice of the appeal decision and all key findings within 45 days of our receipt of your written notice of appeal.

If an appeal decision is partially or wholly adverse to you, you have the right to appeal the decision as described below under *External Review Program*.

How Do You Appeal a Claim Decision?

You have the right to appeal an Adverse Determination of a claim for Benefits; which is defined as a decision by us relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including a decision to deny an admission, extension of stay, or health care service on the basis that the service is not Medically Necessary.

Post-service Claims

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

Pre-service Requests for Benefits

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

Initial determinations on pre-service requests for Benefits will be communicated to you and your provider within five business days after receiving the request if the request is received electronically.

When an initial determination is made not to prior authorize a pre-service request for Benefits, notification will be provided by us within one business day after making the determination to the attending health care professional and Hospital, as applicable.

When an initial determination is made not to prior authorize a pre-service request for Benefits, you will receive written notification that includes the principal reason or reasons for the determination and instructions for initiating the appeals process.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you have the option to appeal in writing or by hearing.

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 chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed 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 related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and 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 related to 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 defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If we are unable to make a decision within 15 days due to circumstances outside our control, we will notify you that it may take up to four additional days to notify you of our decision. We will include the reason for the extension. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
    - If your pre-service request for Benefits appeal does not result in a reverse of the initial determination, you or your health care provider, will be provided the following:
        - A complete summary of the review findings;
        - Qualifications of the reviewers, including any license, certification, or specialty designation;
        - The relationship between your diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

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

Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you, and as applicable, the attending Physician and Hospital, with a written or electronic determination within 48 hours (and must include at least one business day) 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. If your urgent appeal results in an Adverse Determination, the Adverse Determination will include notification of your right to external review.

External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

Please note, you may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

- We waive the exhaustion requirements;
- We are considered to having waived the exhaustion requirements by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or
- You have applied for an expedited external review at the same time you qualify for and have applied for an expedited internal review.

If you have any questions about the external review process, you may call the state of Minnesota *Department of Commerce* at 1-800-657-3602 or the state's external review provider. The state of Minnesota *Department of Commerce* address is:

Minnesota Department of Commerce

Attn: Consumer Services Center

85 7th Place East, Suite 280

St. Paul, MN 55101

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the *Commissioner of Commerce* to the address listed in the determination letter. If you request an external review, we must participate in the external review and the cost of the external review must be borne by us. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the *Department of Commerce* at 1-800-657-3602 (Greater Minnesota only) or 651-539-1600 (complaints), by fax at 651-296-4328 or by e-mail at www.commerce.state.mn.us. A request must be made within six months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review as determined by the *Commissioner of Commerce*.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.

- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)* assigned by the *Commissioner of Commerce*. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A referral of the request by the *Commissioner of Commerce* to the *IRO*.
- A decision by the *IRO*.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 40 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

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

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
    - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Upon receipt of your request, for expedited external review, the *Commissioner of Commerce* will assign an *IRO* in the same manner utilized to assign standard external reviews to *IROs*. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the *Department of Commerce* at 1-800-657-3602, by fax at 651-296-4328 or by e-mail at consumer.protection@state.mn.us for more information regarding external review rights, or if making a verbal request for an expedited external review.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

A. **Plan**. A Plan is any of the following that provides benefits or services for 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 insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); individual insurance contracts; 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; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage

under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

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

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

- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating the Coverage Plan's Benefit in these situations, we use the provider's billed charges as the Allowable Expense.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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

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

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

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

Examples of financial incentives for Network providers are:

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

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost effective setting and/or from Preferred in-Network Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

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

Estimated Reimbursement Request

If you intend to receive specific health care services from a Network provider, you or your designee may request a good faith estimate of the Allowed Amount for that service by calling us at the telephone number on your ID card. We will provide you with a good faith estimate which will include an estimate of your out-of-pocket cost. Effective July 1, 2019, this estimate must be provided within ten business days from the date we receive the complete request.

A good faith estimate is not legally binding, nor is it a guarantee of final costs for services, a final determination of Benefits eligibility or provider Network participation.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

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

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

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

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the

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

Amendments to the Policy

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

How Are Benefits Paid When You Are Covered under Medicare?

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B.

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

Subrogation and Reimbursement

We have the right to subrogation and reimbursement subject to you obtaining full recovery, as explained in *Minnesota Statutes 62A.095* and *62A.096*. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Policy to treat your injuries. Under subrogation, the Policy has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to return to us any payment of Benefits you receive for that Sickness or

Injury pursuant to applicable law. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. Subject to you being fully compensated, we may assert a claim for reimbursement.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- 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 that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will notify us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- We may collect Benefits paid or payable to you or for your benefit from the proceeds of any recovery obtained by you or your legal representative, regardless of form, but only after you have made a full recovery from another source. For purposes of this *Subrogation and Reimbursement* section, full recovery does not include payments made by a health plan to or for your benefit.
- Our rights are subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney. If we are separately represented by an attorney, we will entertain an agreement regarding allocation of costs, disbursements, and reasonable attorney fees and other expenses.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment related to the Benefits provided under this Policy, other than a statutory no-fault wage loss payment, from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- Our right to recovery will not be reduced due to your own negligence.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of

limitations. If ERISA is not applicable, then Minnesota law shall govern our subrogation and reimbursement rights, including as provided in *Minnesota Statutes, section 62A.095* and*.096*.

- You may not release, waive or modify any of our rights, without our written approval.
- In the case of your death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. A release of claims or settlement agreement with another party does not affect our right to seek recovery. 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 any 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.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, pursuant to state law and ERISA (42 U.S.C. 1132) including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

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

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

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you

want to bring a legal action against us you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application*, attached papers and any Riders and/or Amendments, make up the entire Policy that is issued to the Group. No change in the Policy shall be valid until approved by one of our executive officers. No agent has authority to change this Policy or waive any of its provisions.

Section 9: Defined Terms

Adverse Determination - a decision by a utilization review organization relating to an admission, extension of stay, or health care service is partially or wholly adverse to the enrollee, including:

- A decision to deny an admission, extension of stay, or health care service on the basis that it is not Medically Necessary; or
- An authorization for a health care service that is less intensive than the health care service specified in the original request for authorization.

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

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

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

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

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

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

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

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

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

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

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not

include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

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

Benefits - the health care items or services covered under the Policy. Covered Benefits and excluded services are defined in the Policy.

Biomarker Testing - the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to:

- single-analyst tests;
- multiplex panel tests;
- protein expression; and
- whole exome, whole genome, and whole transcriptome sequencing.

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

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

Clinical Utility - a test provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

Community Mental Health Center/Mental Health Clinic - a facility whose primary function is the diagnosis, treatment, and/or rehabilitation of persons with mental or nervous disorders which meets one of the following requirements:

- If the services of the facility are mandated by law, the facility is licensed or approved by the appropriate authority.
- If the services of the facility are not mandated by law, the facility meets all of the following requirements:
  - It is established and operated in accordance with any applicable laws.
  - It is an organization with its own governing body, administration and medical staff.
  - The medical responsibility for patients rests with a Physician.

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

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

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function. However, in no event, will treatment of port-wine stains be considered a cosmetic procedure.

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

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

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

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

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

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, eligibility for enrollment and qualification as a Dependent is administered by the Group consistent with the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child or grandchild.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child or grandchild for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.
- A grandchild of the Subscriber or the Subscriber's covered spouse if the grandchild is financially dependent upon and resides with that covered grandparent continuously from birth.

The following conditions apply:

- A Dependent includes a child listed above under age 26.

- A Dependent includes an Enrolled Dependent age 26 or older who is or becomes disabled and dependent upon the Subscriber. For purposes of this definition, a disabled dependent is a person who is and continues to be both:
    - Incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability.
    - Chiefly dependent upon the Subscriber for support and maintenance.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month during which the child reaches age 26 or as described under the *Coverage for a Disabled Dependent Child* provision in *Section 4: When Coverage Ends*.

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

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

Distant Site - means a site at which a Physician is located while providing health care services or consultations by means of Telehealth.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent.

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

- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility rules in accordance with the Policy which includes this *Certificate* and the Group *Application*. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to severe pain to ensure that the decision to reimburse the Emergency care is not made solely on the basis of the actual diagnosis) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

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

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

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

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

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

  e) Any other conditions as specified by the Secretary.

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

Coverage for these services is available 24 hours a day and seven days a week.

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or

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

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

Exceptions:

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

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

- Drugs for the treatment of cancer if the drug is recognized for treatment of cancer in:
  - Any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biological used off-label.
  - One article found in a major peer reviewed medical journal that has recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed.

  However, Benefits will not be provided when the *FDA* has determined a drug's use to be contraindicated, or when the drug is not approved for any indication by the *FDA*.

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

Gender Affirming Health Care Services - all medical, surgical, counseling, or referral services, including Telehealth services, that a Covered Person may receive to support and affirm that Covered Person's gender identity or gender expression and that are legal under the laws of the State of Minnesota.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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

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

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

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

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

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

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

Independent Freestanding Emergency Department - a health care facility that:

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

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

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

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

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

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

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

Intensive Outpatient Program(s) - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

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

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

Medically Necessary - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, 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), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- The condition, procedure, or treatment at issue and must:
    - help restore or maintain your health; or
    - prevent deterioration of your condition.

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

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

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

This definition of Medically Necessary does not apply to the *Mental Health Care and Substance-Related and Addictive Disorders Services* Benefit under *Section 1: Covered Health Care Services* in the *Certificate of Coverage*. This Benefit has its own definition of medically necessary.

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

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

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

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

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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

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

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

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

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

Originating Site - means a site at which a Covered Person is located at the time the health care services are provided to the Covered Person by means of Telehealth. For purposes of Store-and-Forward Technology, the originating site also means the location at which a Physician transfers or transmits information to the Distant Site.

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

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

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

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, advanced practice registered nurse, physician assistant, pharmacist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician.

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

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

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

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

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

Preferred in-Network Provider - a provider and/or facility that:

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

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

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

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

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

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

Rapid Whole Genome Sequencing (rWGS) - an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient the patient's biological parent or parents.

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

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

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

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

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Store-and-Forward Technology - means the asynchronous electronic transfer or transmission of a Covered Person's medical information or data from an Originating Site to a Distant Site for purposes of diagnostic and therapeutic assistance in the care of a Physician.

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

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

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

Telehealth - means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a Covered Person's health care. Telehealth includes the application of secure video conferencing, Store-and-Forward Technology, and synchronous interactions between a Covered Person at an Originating Site including home or place of work and the Physician at a Distant Site. Until July 1, 2025, telehealth also includes audio-only communication between a Physician and a Covered Person if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Substance-Related and Addictive Disorders Services and Mental Health Care Services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the Covered Person while in an Emergency situation and a scheduled appointment was not possible due to the need of an immediate response.

A communication between Physicians that consist solely of a telephone conversation, e-mail or facsimile transmission does not constitute telehealth consultations or services. A communication between a Physician and a Covered Person that consists solely of an e-mail or facsimile transmission does not constitute telehealth consultations or services. Telehealth does not include Telemonitoring Services except under the following circumstances:

- The Telemonitoring Service is medically appropriate based on your medical condition or status;
- You are cognitively and physically capable of operating the monitoring device or equipment, or you have a caregiver who is willing and able to assist with the monitoring device or equipment; and
- You reside in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Telemonitoring Services - means the remote monitoring of clinical data related to the Covered Person's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a Physician for analysis. Telemonitoring is intended to collect a Covered Person's health-related data for the purpose of assisting a Physician in assessing and monitoring the Covered Person's medical condition or status.

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

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

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

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to

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

Urgent Care Center - an entity that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Section 10: Health Insurance Requirements Regarding Surprise Medical Billing Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balanced billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

Ending Surprise Air Ambulance Bills

Air ambulance transportation that is provided to you by out-of-network providers will be reimbursed at in-network cost sharing rates. Out-of-network air ambulance providers can't balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost sharing for out-of-network services must be applied to your in-network deductible/out-of-pocket maximum.

External Review

You have the right to appeal a health plan's decision if it is related to surprise billing protections that you feel were not properly afforded.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

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

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

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

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

UnitedHealthcare Insurance Company



Robert Hunter, President

Introduction

Coverage Policies and Guidelines

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

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

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

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

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

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Preferred in-Network Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Preferred in-Network Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Preferred in-Network Pharmacy and you choose not to obtain your Prescription Drug Product from a Preferred in-Network Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Smart Fill Program - Split Fill

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

When Do We Limit Selection of Pharmacies?

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

Rebates and Other Payments

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

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

Coupons, Incentives and Other Communications

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

Variable Co-payment Program

Certain Prescription Drug Products, including Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact www.myuhc.com or the telephone number on

your ID card for an available list of Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

The amount of the coupon will count toward any applicable deductible or out-of-pocket limits.

Special Programs

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

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced Benefit based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement by contacting us at www.myuhc.com or the telephone number on your ID card.

Section 1: Benefits for Prescription Drug Products

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

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

See the defined term for a Physician under *Section 9: Defined Term* of the *Certificate of Coverage*. Please note that this would include a pharmacist acting within the scope of their license in regards to prescribing and dispensing the following medications - human immunodeficiency virus (HIV) prevention, self-administered hormonal contraceptives, nicotine replacement medications, opiate antagonists for the treatment of an acute opiate overdose and medications in an emergency as defined by state law.

Coverage for Antipsychotic Drugs not on a Prescription Drug List

Benefits are provided for antipsychotic drugs prescribed to treat emotional disturbance or Mental Illness regardless of whether the drug is on the Prescription Drug List if the Physician prescribing the drug:

- Indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated.
- Certifies in writing to us that the Physician has considered all equivalent drugs on our Prescription Drug List and has determined that the drug prescribed will best treat the patient's condition.

Coverage for Experimental or Investigational Prescription Drug Products for the Treatment of Cancer

Benefits are provided for an *FDA* approved drug to be used for an off-label use if the drug is recognized for the treatment of cancer in:

- One of the following standard reference compendia:
  - *The United States Pharmacopeia Drug Information;*
  - *The American Hospital Formulary Service Drug Information; or*
- One article found in a major peer reviewed medical journal that has recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed.

However, Benefits will not be provided when the *FDA* has determined a drug's use to be contraindicated, when the drug is not approved for any indication by the *FDA*, or if the drug is not on the Prescription Drug List.

Emergency prescription refill

A pharmacist may dispense a maintenance drug without a current prescription drug order from a Physician if all of the following conditions are met:

- The Covered Person has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by records maintained by the pharmacy;
- The pharmacy from which the legend drug is dispensed has a record of a prescription drug order for the drug in the name of the Covered Person who is requesting it, but the prescription drug order does not provide for a refill or the time during which the refills were valid has elapsed;
- The pharmacist has tried but is unable to contact the Physician who issued the prescription drug order, or another Physician responsible for the Covered Person's care, to obtain authorization to refill the prescription;

- The drug is essential to sustain the life of the Covered Person or to continue therapy for a chronic condition;
- Failure to dispense the drug to the Covered Person would result in harm to the health of the Covered Person; and
- The drug is not a controlled substance listed in *MN Statute §152.02, subdivisions 3 to 6,* except for a controlled substance that has been specifically prescribed to treat a seizure disorder, in which case the pharmacist may dispense up to a 72-hour supply.

If the conditions above are met, the amount of the drug dispensed by the pharmacist must not exceed a 30-day supply, or the quantity originally prescribed, whichever is less, except as provided for controlled substances noted under (6) above. If the standard unit of dispensing for the drug exceeds a 30-day supply, the amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

A pharmacist shall not dispense the same drug to the same Covered Person more than one time in any 12-month period.

A pharmacist must notify the Physician who issued the prescription drug order not later than 72 hours after the drug is dispensed. The pharmacist must request and receive authorization before any additional refills may be dispensed. If the Physician declines to provide authorization for additional refills, the pharmacist must inform the Covered Person of that fact.

The record of a drug dispensed under this section shall be maintained in the same manner required for prescription drug orders under this section.

Cost-sharing for Prescription Drug Products And Related Medical Supplies To Treat Chronic Diseases

For Prescription Drug Products prescribed to treat diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors, the total amount of cost-sharing will not exceed $25 per one month supply for each Prescription Drug Product, regardless of the amount or type of medication required to fill the prescription. Your cost-sharing will not exceed $50 per month for all related medical supplies. To comply with federal law, these caps do not apply to Prescription Drug Products or related medical supplies that are not considered preventive care benefits if you have a health savings account (HSA)-compatible high deductible health plan until the Annual Deductible has been met.

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 Preferred in-Network Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Preferred in-Network Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Preferred in-Network Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Preferred in-Network Pharmacy.

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

Prescription Drugs from a Retail Network Pharmacy

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

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

This *Outpatient Prescription Drug Rider* offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.

   The requirement that the *FDA* approve a medication product, or device does not apply to a drug prescribed for the treatment of cancer if the drug is recognized for treatment of cancer in:

   - One of the following standard reference compendia:
     - *The United States Pharmacopeia Drug Information*;
     - *The American Hospital Formulary Service Drug Information*; or
   - One article found in a major peer reviewed medical journal that has recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed.

   However, Benefits will not be provided when the *FDA* has determined a drug's use to be contraindicated, or when the drug is not approved for any indication by the *FDA*.

   This exclusion also does not apply to medications for the treatment of cancer as described under the definition of *Experimental or Investigational Services* found in *Section 9: Defined Terms* of the *Certificate of Coverage*.
7. 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.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which a claim has been paid under any workers' compensation law or other similar laws.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including certainn insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*.

Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
13. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as (a) unit dose(s).
14. Prescription Drug Products used for cosmetic or convenience purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.
18. Certain Prescription Drug Products for tobacco cessation.
19. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on.)
20. The following over-the-counter drugs and products:
    - Drugs or products 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 drug or product 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. This exclusion does not apply to over-the-counter drugs used for tobacco cessation:
    - Over-the-counter continuous glucose monitors; and

    The following Prescription Drug Products with over-the-counter alternatives:
    - Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
    - We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

    The following Prescription Drug Products with over-the-counter alternatives:
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in the *Certificate* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Dental products, including but not limited to prescription fluoride topicals.

30. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the *Certificate*.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products, including associated services.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

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

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

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

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

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

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Certain Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

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

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

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

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- Glucose meters, including continuous glucose monitors.
- All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.

You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical Product as described in the *Certificate* have essentially the same efficacy and adverse effect profile.

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

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company



Robert Hunter, President

UnitedHealthcare Rewards Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards wellness program.

Because this Rider is part of a legal document (the Group Policy), 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 the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse.

UnitedHealthcare Rewards Program

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

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

You may receive one or more of the following:

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

Activity Targets

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

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

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

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

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

Rewards

Rewards listed above, when earned, will be credited to a or distributed in other reward types as applicable, administered by us.

Device

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

UnitedHealthcare Insurance Company



Robert Hunter, President

Notice of Non-Discrimination

We do not treat members differently because of sex, age, race, color, disability, national origin, sexual orientation or gender identity.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, sexual orientation or gender identity, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, Utah 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 180 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

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

You can also file a complaint with the U.S. Dept. of Health and Human services.

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

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

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

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

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

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

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

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

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

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

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

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior

authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

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

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

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

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

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

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

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

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or Pharmaceutical Product(s) for which Benefits are provided as described under the *Certificate* first.

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

When a step therapy requirement applies to a Prescription Drug Product, your provider may request an exception:

- For non-urgent step therapy exception requests, a review will be completed within five (5) days once all information needed to process the request has been received.
- For urgent step therapy requirements, a review will be completed within 72 hours once all the information needed to process the request has been received.

If your step therapy request is denied, please refer to *Section 6: Questions, Complaints and Appeals* in the *Certificate of Coverage* for additional information on appealing an adverse determination.

When coverage is provided for the treatment of stage four advanced metastatic cancer or associated conditions, coverage for an *FDA* approved drug that is on your prescription drug formulary will not be limited or excluded from coverage by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

- A *United States Food and Drug Administration*-approved indication; and
- A clinical practice guideline published by the *National Comprehensive Care Network*.

What Do You Pay?

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

Patient Right to Know Drug Prices Act

We don't directly or indirectly restrict any pharmacy that dispenses a prescription drug from informing the Covered Person of any differential between the Covered Person's out of pocket cost under the plan or costs the Covered Person would pay for the drug without using any health plan or health insurance coverage.

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

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. *For Prescription Drug Products that contain insulin and are used to treat diabetes, your payment will not exceed the net price of the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

Payment Term And Description	Amounts
number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Variable Co-payment Program**: Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a coupon. Contact www.myuhc.com or the telephone number on your ID card for an available list of Prescription Drug Products and the applicable Co-payment and/or Co-insurance. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone	

Payment Term And Description	Amounts
number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. Notice will be provided thirty (30) days prior to a negative change. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance as permitted by federal law.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Preferred in-Network Pharmacy.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $15 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $45 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $85 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $200 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $15 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $45 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $85 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $200 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to 12 cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied when applicable. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Insulin: None For a Tier 2 Insulin: $15 per Prescription Order or Refill For a Tier 3 Insulin: $25 per Prescription Order or Refill For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $85 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: None of the Prescription Drug Charge after you pay $200 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to 12 cycles at one time if you pay a Co-payment and/or Co-	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Insulin: None For a Tier 2 Insulin: $15 per Prescription Order or Refill For a Tier 3 Insulin: $25 per Prescription Order or Refill For a Tier 1 Prescription Drug Product: None of the Out-of-

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
insurance for each cycle supplied when applicable. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Network Reimbursement Rate after you pay $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $85 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $200 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products* You may obtain up to 12 cycles of contraceptives at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied when applicable. You may be required to fill the first	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Insulin: None For a Tier 2 Insulin: $37.50 per Prescription Order or Refill For a Tier 3 Insulin: $62.50 per Prescription Order or Refill For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $37.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $112.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $212.50 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate or for 12 cycles of contraceptives at one time. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills or for a 12 cycle supply for contraceptives.	For a Tier 4 Prescription Drug Product: None of the Prescription Drug Charge after you pay $500 per Prescription Order or Refill.

Language Assistance Services

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-866-633-2446. (TTY: 711).

ማሳሰቢያ፦ **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በ 1-866-633-2446 ይደውሉ።

لاحظة: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم 1-866-633-2446.

দেখুন: আপনি যদি **বাংলায় (Bengali-Bangala)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো, অন্যান্য ফরম্যাটে বিনামূল্যে যোগাযোগগুলি, আপনার জন্য উপলব্ধ। 1-866-633-2446 এ কল করুন।।

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ **ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជា ពុម្ពអក្សរ ជំ មានសម្រាប់អ្នក។ ទូរសព្ទទៅលេខ 1-866-633-2446។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale toor kapetal. Ko yegili 1-866-633-2446.

ATENSYON: Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hågu ni' fåtto, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang 1-866-633-2446.

請注意：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電1-866-633-2446。

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl Ayisyen (French Creole-Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma ki disponib, tankou sa ki enprime ak gwo lèt yo. Rele 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie 1-866-633-2446an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. 1-866-633-2446 પર કૉલ કરો.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। कॉल करें 1-866-633-2446।

LUS TSEEM CEEB: Yog tias koj hais **Lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus pub dawb thiab muaj kev sib txuas lus dawb ua lwm hom ntawv, xws li luam ntawv loj rau koj. Hu rau: 1-866-633-2446.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti 1-866-633-2446.

ATTENZIONE: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero 1-866-633-2446.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。1-866-633-2446にお電話ください。

알림 사항: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사소통 매체를 이용하실 수 있습니다. 1-866-633-2446번으로 전화해 주십시오.

ໝາຍເຫດ: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊັ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່. ກະລຸນາໂທຫາ 1-866-633-2446.

BAA'ÁKONÍNÍZIN: **Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáá łahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Kohjį' 1-866-633-2446 hodíilnih.

ध्यान दिनुहोस्: तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। 1-866-633-2446 मा कल गर्नुहोस्।

WICHDICH: Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht, kenne mer dich Schprooch-Hilf un annri Sadde Schreiwes griege, so wie Grooss-Druck (large print), unni as es dich ennich eppes koschde zellt. Call 1-866-633-2446uff.

توجه: اگر به زبان **فارسی (Persian-Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با 1-866-633-2446 تماس بگیرید.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para 1-866-633-2446.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। 1-866-633-2446 ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по номеру 1-866-633-2446.

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan-Fa'asamoa)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au i le 1-866-633-2446.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac 1-866-633-2446.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al 1-866-633-2446. (TTY 711).

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa 1-866-633-2446.

โปรดทราบ หากคุณ**พูดภาษาไทย (Thai)** ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทร 1-866-633-2446

ЗВЕРНІТЬ УВАГУ! Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на номер 1-866-633-2446.

توجہ دیں: اگر آپ **اردو (Urdu)** زبان بولتے ہیں تو زبان کی معاون خدمات اور دیگر فارمیٹس میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ کال کریں 1-866-633-2446۔

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi 1-866-633-2446.

Notice of Non-Discrimination

We[1] comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race color, national origin, age, disability or sex.

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

If you need these services, please call 1-866-633-2446 or the toll-free member phone number on your member ID card, TTY/RTT 711.

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

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your member ID card, TTY/RTT 711.

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

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

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

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

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

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

[1]For purposes of this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

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 as defined above, 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 considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, 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 pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed 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 related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge 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

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 shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

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

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

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE

Effective January 1, 2025:

We[2] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment,** including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician

to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsor,** if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive or Sexual Health
    11. Sexually Transmitted Diseases

We will follow the more stringent law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already

acted based on your authorization. For more information on how to revoke your authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** To exercise any of your rights described above. Mail your written requests to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint or Grievance.** If you believe your privacy rights have been violated, you may file a complaint or grievance with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Health Plan Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; First Risk Advisors, Inc.; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; Healthplex Insurance Company; HealthSmart Primary Care Clinics, LP; International Healthcare Services, Inc.; MAMSI Life and Health Insurance Company; Managed Care of North America, Inc.; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; New Orleans Regional Physician Hospital Organization, L.L.C.; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Network, Inc.; Preferred Care Network of Florida, Inc.; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New

England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, on the last page of the Health Plan Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: Ritalka Inc

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Ritalka Inc

121 N 1st St

Montevideo, MN 56265

(320) 309-3450

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 41-1897814

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Ritalka Inc

121 N 1st St

Montevideo, MN 56265

(320) 309-3450

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, CT 06103-0450

877-294-1429

Person designated as Agent for Service of Legal Process: Designated agent here

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to

determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.